DVA COMMUNITY (CONTRACT) NURSING HOME CARE PROGRAM

HEARING

BEFORE THE

SUBCOMMITTEE ON
OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FIRST CONGRESS

SECOND SESSION

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DVA COMMUNITY (CONTRACT) NURSING HOME CARE PROGRAM

Wednesday, March 28, 1990

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The subcommittee met, pursuant to notice, at 9 a.m., in room 334, Cannon House Office Building, Hon. Lane Evans (chairman of the subcommittee) presiding.

Present: Representatives Evans, Kennedy, Long, and James.

OPENING STATEMENT OF CHAIRMAN EVANS

Mr. EVANS. The hearing will come to order. Good morning and welcome.

This fiscal year, the Department of Veterans Affairs expects to provide care in community nursing homes to nearly 32,000 veterans. This is nearly a 25 percent reduction from the level of care provided by this program in fiscal year 1988.

This committee is concerned about the extended care needs of veterans. In its recent report to the Budget Committee, our committee, I'm proud to say, unanimously recommended $96 million more than the President had requested for community nursing home care next year. This would restore this program to the level of care provided in fiscal year 1988.

I am also proud that we unanimously recommended $16 million more than the President's budget request for grants to construct State facilities which provide extended care to veterans.

Under current Department policy, community nursing homes are to provide 40 percent of the extended care furnished by the VA. This care is furnished on a negotiated, contractual basis. In recent years, a score of Inspector General audits have reported findings on the Community Nursing Home Program. Those findings suggest improvements in this program are needed. We want to review those findings today as well as the policy on provider mix.

By virtue of an aging veteran population, by the year 2000 the number of veterans provided VA care in community nursing homes is forecast to increase by nearly 100 percent. A solid program and policy foundation is needed to support this future expansion.

At this time, I would like to recognize the gentleman from Florida.

OPENING STATEMENT OF HON. CRAIG JAMES

Mr. JAMES. Mr. Chairman, I apologize for the absence of the ranking minority member. Mr. Stump is unable to be here because of a serious family illness.

Mr. Chairman, Republican and Democratic colleagues, representatives of the Department of Veterans Affairs, and veterans, we are here today to hear testimony regarding the present and future state of the Community Nursing Home Program for the Department of Veterans Affairs.

The Community Nursing Home Program treated over 42,000 veterans last year nationwide. This was at a time when veterans 65 years of age and older comprised just 26 percent of the eligible veterans population. Current estimates show that this group will increase to over 40 percent of the eligible veterans population by the year 2010. As this population grows, the need to provide adequate nursing home care will grow right along with it.

The statistics cannot be ignored. The growing need cannot be denied. The community nursing home provides an invaluable service to aging veterans. In Florida alone, the VA has contracted with 187 nursing homes. Obviously, the need for this program is increasing and will continue to do so long into the future.

We must respond to the challenges confronting this program. We can no longer delay. We can and must meet these challenges now. We must examine this program and find the best way to provide for the health care needs of those men and women who served and sacrificed for this Nation with patriotism, courage, and honor.

I look forward to hearing the testimony of our panel and their analysis of the challenges currently confronting us.

Thank you.

Mr. EVANS. Thank you.

The members of our first witness panel today are Mr. Ren Morani, Dr. Daniel Winship, Dr. Thomas Yoshikawa, Mr. Lee Harper, and Mr. Ralph Ibson. Will they please come forward and be seated.

Ren is the acting Inspector General of the Department of Veterans Affairs. Dr. Winship is the Associate Deputy Chief Medical Director of the Veterans Health Services and Research Administration, Department of Veterans Affairs. He is accompanied today by Dr. Thomas Yoshikawa, the Assistant Chief Medical Director for Geriatrics and Extended Care; Lee Harper is the Assistant Deputy Assistant Secretary for Acquisitions; and Ralph Ibson is Deputy Assistant General Counsel.

We want to welcome you all today. With the exception of Lee Harper, each member of the panel has previously testified before the subcommittee. We welcome you back and want to extend a special welcome to Mr. Harper.

Ren, we will begin with you. Please proceed whenever you are ready. As you know as an experienced witness, we will include your entire statement in the record. If you could summarize we would all appreciate it.

STATEMENTS OF RENALD P. MORANI, ACTING INSPECTOR GENERAL, DEPARTMENT OF VETERANS AFFAIRS; AND DR. DANIEL H. WINSHIP, ASSOCIATE DEPUTY CHIEF MEDICAL DIRECTOR, DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY: DR. THOMAS T. YOSHIKAWA, ASSISTANT CHIEF MEDICAL DIRECTOR FOR GERIATRICS AND EXTENDED CARE; ERNEST L. (LEE) HARPER, ASSISTANT DEPUTY ASSISTANT SECRETARY FOR ACQUISITIONS; AND RALPH IBSON, DEPUTY ASSISTANT GENERAL COUNSEL

STATEMENT OF RENALD P. MORANI

Mr. MORANI. Thank you, Mr. Chairman and members of the subcommittee. I am pleased to be here today to discuss the results of our audits of the Department's Contract Community Nursing Home Program.

Community nursing home care was authorized by Public Law 88-450 in August 1964. The law authorized the VA to transfer veterans needing nursing home care to community or non-VA facilities instead of providing them similar care in VA hospitals that would cost more than community nursing homes. The VA had about 3,900 contracts as of June 30, 1989, and spent about $251 million.

In 1986, we performed a national audit of contract rates for community nursing home care. The audit identified at that time that an estimated $61 million annually could be made available for other veteran health care needs if VA medical centers' negotiated rates for community nursing home care based on Medicaid rates plus actual costs for additional services not covered by Medicaid.

The Chief Medical Director and the then Director of the Office of Procurement and Supply concurred with the audit recommendations and agreed to issue clarified policies and procedures. The Chief Medical Director also agreed to issue a policy requirement that periodic market surveys be conducted by VA medical centers to help increase competition among nursing homes. These policy changes were published in July 1988.

During fiscal year 1987 through the first quarter of fiscal year 1990, continued weaknesses have been identified during our facility audits and the contract negotiation process for obtaining community nursing home care. Our audits at 24 medical centers show that about $7 million annually could have been used for other health care needs if medical centers complied with agency policy requirements to use Medicaid rates and actual cost data as the basis for awarding contracts.

Our current audits continue to show that contract negotiation procedures needed improvements for two main reasons. One, contracting officers were not using Medicaid rates to negotiate prices for contract care; and, two, they also did not obtain supporting cost data from nursing homes to justify awarding rates that exceeded Medicaid rates plus the 15 percent supplemental.

In view of the repeat findings in the contract negotiation process along with continued increases in daily cost of contract care, we recently initiated a national audit to follow up on our 1986 audit, summarized the results of the 24 medical center audits, and evaluated the current situation nationally. We wanted to determine if

and why VA medical centers continue to have difficulties in establishing reasonable contract rates and the problems the centers had in the contract negotiation process. We have not finalized our summation of this current audit, but we can offer the following concerns at this time.

More effective compliance is needed by contracting officials with the VHS&RA policy on using Medicaid rates or actual cost data as the basis for awarding contracts and better understanding is needed by contracting officials of the structure of the Medicaid rates to determine whether these rates truly reflect market values of nursing home care in their communities.

VA contracting officials typically are not in a strong negotiating posture, as noted by the fact that less than 2 percent of the contracted facilities' beds are occupied by VA patients, and agency policies have been oriented towards paying for cost of care while nursing homes are profit oriented; VA often authorizes short-term nursing home care contract periods for veterans, while many nursing homes are traditionally and primarily long-term care facilities; and, finally, a need for an effective oversight system that would help ensure contracts are awarded in the most efficient, effective, and economical manner.

In summary, Mr. Chairman, our review of the Community Nursing Home Program continues. However, at this time it appears that agency policies and procedures may require change to have VA medical centers' contracting personnel use financial or cost report data as the primary basis for determining reasonable contract rates instead of Medicaid rates. Also, guidelines for determining acceptable profit margins for community nursing homes also may need to be developed. Additionally, improvements in internal controls would be in order to strengthen compliance with policies and procedures and to include a better reporting system that would allow central oversight and coordination of facility contracting.

If the large increase in contract nursing home care projected for fiscal year 2000 and beyond is accurate, effective procedures and controls must be put in place now to ensure that needed care is obtained in the most cost efficient manner.

Mr. Chairman, that concludes my oral statement. We would be pleased to answer any questions you might have.

[The prepared statement of Mr. Morani appears on p. 27.]

Mr. EVANS. Thank you.

Dr. Winship.

STATEMENT OF DR. DANIEL H. WINSHIP

Dr. WINSHIP. Thank you, Mr. Chairman.

It is a pleasure to appear before the subcommittee to discuss the Department of Veterans Affairs' Community Nursing Home Program. This program is one of three VA-sponsored programs that provide nursing home care to veterans. The other two are the VA-operated nursing homes and the State Home Program.

The Community Nursing Home Program contracts with approximately 3,400 nursing homes around the country and treats a large number of veterans, some 32,000 per year. It is the largest of the three programs. The Community Nursing Home Program really

provides a transition from hospital care to community living, or it may allow time for the patient and the family to make other arrangements for continued care. The program is available for non-service-connected as well as service-connected veterans, but the rules are different for each of those groups. For non-service-connected veterans, for example, the placement is not to exceed 6 months, although in certain circumstances placement may be extended for 45 days. Veterans who need nursing home care for service-connected conditions may be placed indefinitely.

VA contracts only with those homes that meet VA standards, which are greater than community standards in certain areas, such as for patient care, staffing levels, and fire safety. For example, VA requires the latest edition of the life safety code and for intermediate care facilities VA requires licensed nursing coverage at all times.

The process by which VA enters into a contract with a nursing home includes an interdisciplinary team review and an evaluation of the nursing home by a team, a skilled and multi-disciplinary team. VA does not regulate nursing homes but evaluates them and contracts only with nursing homes that meet VA standards. Also, VA carries out monthly follow-up visits to veterans who are in nursing homes mainly to identify and to resolve any health or post-placement issues concerning those veterans.

In fiscal year 1989, the VA spent $281 million for the treatment of over 32,000 veterans and program support in the Community Nursing Home Program. The fiscal year 1990 budget included $286 million for program support and treatment, and the estimated per diem rate, on the average, for fiscal year 1990 is $77.96. The President's budget for fiscal year 1991 includes some $300 million for the Community Nursing Home Program.

In establishing contract rates, the VA medical centers are instructed to negotiate an all-inclusive rate which covers all nursing home services. Medicaid, on the other hand, which is the benchmark against which we are to negotiate, is a rate which does not include all services. Medicaid rates cover only room, board, and general nursing care; other services are billed separately under Medicaid. Therefore, the medical centers are directed to use the nursing home's Medicaid rate as a basis for the negotiations and then add up to 15 percent to those rates as payment for the rest of the care. If the rates are going to be higher and need to be negotiated higher, then justification for those higher rates must be brought forward.

We are reviewing our approach to community nursing home rate setting right now. It is a very complex subject, and it is going to become even more complex with the elimination of the distinction between skilled and intermediate levels of care in October of 1990. Meanwhile, medical centers have the flexibility that they need to negotiate properly justified rates that reimburse the homes for their costs.

As indicated, we are not in a particularly strong position for these negotiations. The community nursing homes, in the main, don't need us. We provide less than 2 percent of their business, and so in a business that is burgeoning as the nursing home business is, VA does not have a strong position.

The IG has identified some instances of noncompliance with the Medicaid plus 15 percent rules and in some cases found that there is insufficient documentation of some of our actions to justify rates above what the policy would indicate. Further, sometimes there is not sufficient information or cost information to determine whether our rate really is close to the cost of care.

We responded to the audit findings and changed and strengthened the policy manual on rate negotiations. We have offered detailed instructions on rate setting. We have had two national teleconferences on the subject, workshops at the national conference, and are planning and preparing additional directives. We expect the program to grow in the future, as has been indicated, and to continue as an important part of our long-term care program.

In summary, the Community Nursing Home Program is an essential component of VA's Nursing Home Care Program. Significant growth in this program is projected as a major part of our plans to meet the future needs for nursing home care. We believe the program is well managed both nationally and locally. Audits have identified the need to better document rate decisions in certain instances. We agree with that, and we will certainly follow through to be sure this is done.

Mr. Chairman, this concludes my remarks. I will be pleased to answer any questions that you or members of the subcommittee have.

[The prepared statement of Dr. Winship appears on p. 32.]

Mr. EVANS. Let me begin with a statement you made toward the end of your testimony. On average, the VA program accounts for 1 to 2 percent of the market for nursing home services. Is that 1 to 2 percent of a respective nursing home or 1 to 2 percent of the market nationwide?

Dr. WINSHIP. That is for all nursing homes. We are less than 2 percent of all expenditures for nursing home care.

Mr. EVANS. But, on average, isn't it true that there are at least nine beds in most of these nursing homes?

Dr WINSHIP. Dr. Yoshikawa, can you help me with that?

Dr. YOSHIKAWA. Somewhere between two and three beds; I think it depends on the geographic locations of the VA facility.

Mr. EVANS. Between what? I'm sorry.

Dr. YOSHIKAWA. Between two and three beds.

Mr. EVANS. Five and nine. I would think five to nine, on average, means a significant number. It is certainly better than empty beds as far as the nursing home is concerned. So I wouldn't be too persuaded by the fact that they only represent 1 to 2 percent. That is 1 to 2 percent that they can use in terms of services.

Your statement also refers to the goal of providing care to 16 percent of the total veterans expected to need care. Can you tell us how that goal was established?

Dr. WINSHIP. That goal has been present for quite a while. It is a goal that we have made decisions to stay with, I think in the main because it has been based, in part on historical data.

There has been a fair amount of interest and discussion about whether that goal should be higher in the future. We have had a number of discussions about whether it should be up nearer the

level of 20 percent, which might more accurately reflect the current actual use of nursing homes and treatment of our patients.

Mr. EVANS. We have a backlog now in terms of demand. Can you tell us something about the veterans, perhaps that 80 to 84 percent that are being turned away, who don't have access? Who is providing them extended care, and how does that work for them?

Dr. WINSHIP. In the main, those that we are not providing extended care for in our program are provided extended care, when they receive it, through Medicaid programs or other community programs. We assist veterans in making arrangements for post-hospital care through our discharge planning program, an activity that has really increased and burgeoned, frankly, in recent years. One major activity of that group is, even on admission or early in admission, to try to identify, for those patients who may need long-term care, what other community resources are available. The most important resource would be Medicaid.

Mr. EVANS. This year, the VA's Community Nursing Home Program will provide care to about 25 percent fewer veterans that it did 2 years ago. Can you tell us why the Department has drastically reduced the numbers of veterans provided care in this program?

Dr. WINSHIP. Yes. In fiscal year 1989, the budget that we had for the community nursing home was somewhat in excess of $300 million, but, because of other funding considerations and budget problems in fiscal year 1989, we elected to use the account of the community nursing home as an account against which individual medical centers could draw funds for other purposes. The trade-off would be, of course, to become more efficient in the use of those funds and to provide other mechanisms for taking care of those patients.

So the problem was the overall budgeting shortfall of the VA and the fact that this was an account which was available to us for use for other purposes. The account was therefore unearmarked during fiscal year 1989, and each medical center was then given permission to use that account for what purposes it saw fit. Therefore, the reduction in the account went from approximately $300 million to some $250 million in overall use.

Mr. EVANS. The VA is presently reviewing its approach to community nursing home rate setting. Can you tell us the objective of the review and when it will be completed?

Dr. WINSHIP. Dr. Yoshikawa, I believe, could give us some information about that.

Dr. YOSHIKAWA. We have been looking at it this year, and we will continue looking at whether the Medicaid rate, as Mr. Morani mentioned, is a proper rate. Secondly, in terms of oversight, we are concerned that when rates are set the medical center director should be certifying the rates set by each VA medical center.

Mr. EVANS. At this time, I would like to yield to the gentleman from Florida.

Mr. JAMES. Yes Dr. Winship:

What bothers me is it appears to me that since you are shifting the monies from that account to medical treatment, in Florida our veterans can only get benefits or treatment, of course, when it is for service-connected injuries or disabilities.

Dr. WINSHIP. For long-term care, you mean.

Mr. JAMES. Basically, for any care which is provided in Florida. If it is not service-connected, you don't get treatment.

Dr. WINSHIP. I believe I would include Category A patients or the other types of Category A patients in addition to those that are characterized as being service-connected. I believe the Florida hospitals are doing fairly well in terms of taking care of the Category A patients. A major proportion of those, of course, are the service-connected patients, but also the indigent patients are receiving care there as well.

Mr. JAMES. By and large, from most of the veterans I hear, if it is not service-connected, you don't get it. There is such a short supply of services available, almost everything is service-connected, with the exception perhaps of indigent care.

Dr. WINSHIP. Yes, that is correct. With the exception of indigent care, that is correct.

Mr. JAMES. Okay, and which is very difficult to qualify for in most cases, and, quite frankly, I haven't discussed with them recently to what extent there is a problem in that area. I am sure there is a tremendous problem even in that area.

But, be that as it may, in the nursing homes you allow 6 months, regardless of whether it is service-connected. Is that correct?

Dr. WINSHIP. At the present time, the regulations allow 6 months for non-service-connected veterans; a service-connected patient has a longer time, in fact.

Mr. JAMES. Right. So when you shift the money from that account, isn't a State like Florida being disenfranchized to the extent of that 6 months for non-service-connected veterans? In other words, it is going to the service-connected injuries and you are not getting nursing home care at all for a percentage of the veterans on that 6 month allowance.

Dr. WINSHIP. That is correct.

Mr. JAMES. So that policy is discriminating disproportionately against my State the way I read it.

Dr. WINSHIP. I would say that it may be discriminating against the non-service-connected veteran, but not the State of Florida.

Mr. JAMES. Right. That is what I am talking about. We are talking veterans here.

Dr. WINSHIP. But I think there is another issue that is entering in that we haven't established the data for yet.

Mr. JAMES. So that would bother me. Can you understand how that policy would disturb me for my veterans in Florida, which has a very high percentage of veterans?

Dr. WINSHIP. Of course.

Mr. JAMES. The next question that I have: in my State, you can qualify for Medicaid, and the State will pick up the Medicaid nursing home expenses, of course, if you are indigent; you have to have just no assets basically. They will only pay a certain prescribed rate of pay. What is the distinction between that and the way the VA pays?

Dr. WINSHIP. I am not quite sure I understand.

Mr. JAMES. In other words, the State is going to pay a nursing home "X" amount of dollars, and they will only take a patient and give "X" amount of dollars; it changes, but it is much less than many nursing homes charge. I have had many clients that got the

benefit of the State pay. In other words, they may charge $2,000 a month, but, otherwise, if the individual has no money the nursing home will still take them for, let's say, $1,400 a month. To what extent does that same theory apply with the VA paying? I say that because of your testimony. You said the audit identified that an estimated $61 million annually could be made available for other veteran health care needs if VA medical centers negotiated rates for community nursing home care. That was in your 1986 analysis.

Dr. WINSHIP. The VA attempts to negotiate rates that reflect cost and a reasonable return on investment.

Mr. JAMES. I'm sorry, that was Mr. Morani's statement. First, do you identify with that statement? That is what leads me to the question, though.

Dr. WINSHIP. We agreed with the substance of the problem but the number of $61 million and the calculation of that I think we would have some disagreement about. But that is not really the point that is at issue. The negotiating point is, we are in agreement on that.

Mr. JAMES. What I am really getting at is, why don't we do like Medicaid and say we will pay "X" amount of dollars? The State of Florida does not negotiate, or Medicaid does not negotiate, they just tell you what they will pay, and most of the people get in the nursing homes. There are some nursing homes that won't accept it, but many of them will.

Dr. WINSHIP. That is correct. I guess the reason that we don't do exactly what Medicaid does is because we deal with all the States, and Medicaid rates in different States are different, they are not standard across the country at all. But I think you are talking about the principle.

Mr. JAMES. The principle.

Dr. WINSHIP. We have accepted the principle that we will attempt to pay cost, and Medicaid does not attempt to pay cost, and so the basic premise upon which we operate, I think, is different from Medicaid. We could discuss whether we should change that premise, and I think that is what you are asking.

Mr. JAMES. Yes, you are right, that is what I am asking. Should we not follow the Medicaid approach, because you have acknowledged there is a problem with negotiation, okay?

Dr. WINSHIP. That is correct.

Mr. JAMES. Medicaid doesn't negotiate.

Dr. WINSHIP. Yes, we have had those discussions internally and have come down on the side of being more responsible about that and being more uniform across the country and, therefore, trying to base it on cost.

Now, where we get into trouble is that we use the benchmark of Medicaid rates as the starting point and then to add on to that up to a certain percentage so that we are actually covering the costs to the nursing home. I think the problem with that exercise is that that benchmark is not the same benchmark throughout the country and it does not in any way relate to costs.

So our fundamental posture is one that we believe is a responsible one, while it can be an efficient one, and that is to relate our payment to the nursing home in terms of cost and not some arbitrary figure that is otherwise decided upon.

Mr. JAMES. Okay. Accepting that you don't like the way Medicaid comes up with what you just characterized as arbitrary as far as their evaluation—

Dr. WINSHIP. Not based on cost, correct.

Mr. JAMES. Yes. I think you used the word "arbitrary" or "not based on cost." Whatever, assuming the veterans can come up with a superior standard then, it would seem to me that, still, the technique they use may have some validity, that is to say, not negotiate but say, "This is what we will pay." Now that may be living in a harsh world, but I find it very harsh when we have many veterans that are otherwise just excluded entirely, if you can follow what I am saying, especially, as in my State, I am concerned. You have just said, "We shift funds," and that seems to me to discriminate against those growth States.

Dr. WINSHIP. I think all of what you say is true, and I think that is certainly one way that we can look at that. As we are taking the relook at our community nursing home rates and our rate-setting methodology, I think what you say is certainly worth considering as we are trying to debate how to go about doing that in the best way and getting the most mileage from what we are spending.

Mr. JAMES. What I want is fairness to the different veterans and the different States, not some shifting to a different program that has different economic ramifications.

Dr. WINSHIP. There is one element of fairness, and that is that the ceiling rate above which we will not go unless an exception is justified by a quite different process is the same for all the States. Therefore, that is a fixed level of pay. We try to negotiate below that level, is what it amounts to.

Mr. JAMES. Thank you so very much. I want to thank you all for your testimony. It helps me understand the problem. Being a new person on the committee, it is very helpful to try to discuss these problems with some degree of knowledge. Thank you so much. I see my time is up, and you have been very kind to respond to my questions. Thank you all.

Dr. WINSHIP. Thank you, sir.

Mr. EVANS. Before I yield to the gentleman from Massachusetts, I would just like to say that the chair is very familiar with the numbers of former Illinoisans who have moved to Florida and concerned particularly about the plight of those people, as Mr. James has indicated, that fall into the non-service-connected categories and are not receiving health care. I thought it might be very useful if you could provide the committee, perhaps, with data for the Florida medical centers that have jurisdiction over these nursing homes, perhaps just of the numbers of people in the different categories that are currently receiving nursing home care.

Dr. WINSHIP. In Florida?

Mr. EVANS. Yes, in Florida.

Dr. WINSHIP. We would be happy to do that.

Mr. EVANS. The subcommittee will be traveling to Florida in June. If we could get those figures before then to explore some of these problems, it would be very useful in our consideration of those issues there.

Dr. WINSHIP. We would be happy to.

(Subsequently, the Department of Veterans Affairs furnished the following information:)

In FY 1989, the distribution of patients by means test category in the Community Nursing Home Program in the State of Florida was: Category "A"—97.6 percent; Category "B"—1.8 percent; Category "C"—0.1 percent. (Note: the percentages do not add to 100 percent due to rounding).

Mr. EVANS. Also, if you disagree with the $61 million figure, is there a figure that you can agree on that could be used for other health care needs?

Dr. WINSHIP. No, I cannot, because I think the basis for the disagreement is that that is a calculated number comparing what we actually spent and what the Medicaid rate plus 15 percent would be. Therefore, there is a gap there that does not take into account whatever possibilities there are for negotiation between those two numbers, and since those negotiations were not carried out in each one of those instances there is simply no way to know what saving would have occurred, if any. Therefore, there is no way to know what that difference might be.

Mr. EVANS. Let me ask the IG if he has any response to that question.

Mr. MORANI. Mr. Chairman, that is basically the correct answer in terms of quantifying the difference. However, the other side of the equation is that many examples were noted where costs were less than the Medicaid rate. So, you have shifts up and down. We quantified the $61 million to give an idea of the current efforts that should be done in this particular area to truly get reasonable and fair rates applicable to these contract nursing homes.

Mr. EVANS. All right. Thank you.

The gentleman from Massachusetts.

Mr. KENNEDY. Thank you, Mr. Chairman.

I, first of all, want to thank you for having these hearings on what is a very important issue in terms of the future of the Department of Veterans Affairs.

Dr. Winship, I just have some general thoughts. You indicate in your testimony that in this year it is the VA's goal to provide care for 16 percent of the total veterans expected to need nursing home care. I have an article before me in a Massachusetts paper that indicates that there are some 1,660 patients statewide that are ready to enter nursing homes but, instead, wait in hospitals for an average of 3 months. It goes on to indicate that in Massachusetts the average hospital day costs $559 and that theoretically that would add an additional $83 million worth of cost to the care of providing people that space they are taking up in hospitals when they would be better off in nursing homes.

I wonder what your thoughts are in terms of where the VA is in that process. Going back to Mr. James' point, the fact is that in Massachusetts we face the same kinds of circumstances where people are, in fact, turned down at the VA medical centers simply because they don't have the personnel to take care of them. They might not be told that they can't get the operation, but they are certainly told to come back several months later.

So the bed shortage is critical, and if we have people that are, in fact, taking up that space, obviously, they are taken up in a way that effects the normal health care delivery system.

So I just wonder, in general, what your thoughts are about the size of this phenomenon in the VA.

Dr. WINSHIP. Mr. Kennedy, thank you for that question because that is, I think, a very penetrating one, and I think that you have focused on a very interesting problem.

A lot of those patients stay in the VA bed, an acute-care bed, sometimes because a nursing home bed simply isn't available because there are a number of obstacles to out-placing those patients, only one of which may be whether we can afford a nursing home bed or not.

We have some data that have been provided to us, not done internally, and then some that have been done internally to follow up to try to determine how many such patients there are, and the numbers really are not very satisfactory because there is little consensus on the instrument that is used to try to determine whether a patient should be in a bed or should not be in a bed.

Be that as it may, I believe that the problem is one that is fairly substantial. We have made a very substantial effort over the last few years to markedly improve our discharge planning program to try to appropriately place these veterans. Discharge planning is the key to getting the patient out of the bed that the patient no longer needs to be in and into whatever other kind of care, or out of the hospital, at home, or whatever, that the patient needs.

I must tell you that I don't think that that effort is nearly as good yet as it needs to be, and I think that is one of the major problems. You have identified a very significant problem, and I cannot give you any reliable data that says how large the problem is.

Mr. KENNEDY. I was interested in this, Doctor, if you could just tell me this. You mentioned that funding is not necessarily the only—I can't remember your exact words, but you were indicating that maybe it is not even the most important reason why the patients aren't being moved out of acute care facilities. What would be the other reasons?

Dr. WINSHIP. I am just saying that that is not the only reason and there are other reasons. Nursing home care is not the only way to discharge a patient. We don't discharge anywhere near all of our patients to nursing home care.

Mr. KENNEDY. Okay. We don't have to get into that in great detail. I agree, there are people who get out of hospitals for other reasons than to go into a nursing home.

Dr. WINSHIP. Right.

Mr. KENNEDY. But that wasn't really what we were talking about. What we were talking about was whether or not there are patients in hospital beds that could be moved into nursing homes and that they are, in fact, taking up an acute care facility at a very large cost to the VA that could be deferred and result in dollars saved.

What I am trying to get a better understanding of is, if, in fact, that is occurring, then to what degree is it occurring and whether or not we couldn't, in fact, save hospital beds and the dollars that would be involved with those beds and, in fact, turn those over for a net cost saving to the VA by getting those patients into the nursing homes rather than having them sit in the hospital. Is this something you could do internally? I don't know; maybe there is

some problem with it, Doctor. You just tell me. Is there a problem that would make it a difficult study to conduct?

Dr. WINSHIP. I think the study would be difficult to conduct, but I think it is not impossible to conduct.

I would say that your assumption is correct. All of us certainly recognize that there are patients in acute care beds that should be in nursing home care beds, and the problems in getting them there are sometimes financial, sometimes shifting of funds, and sometimes other kinds of obstacles. I cannot give you data about the magnitude of the problem, but I certainly agree that the problem is there.

Mr. KENNEDY. I appreciate what you are saying, and all I am pointing out to you is that, even if you would suggest that there are other reasons, the fact is that it would be a net cost saving.

Dr. WINSHIP. Yes.

Mr. KENNEDY. So I just would think, whether or not you are going to use the cost savings to pay for more sick patients to come into the VA or whether you are going to use that to shift to take care of less sick patients that can go into nursing homes, the fundamental fact is that we are allowing an inefficient system to continue, and I would think that the way to approach it would be to come up with a reasonable study.

These are very specific numbers on the Medicare problem in the State of Massachusetts, so I think there is some sort of process that you can go through, there is some sort of study that can be conducted that identifies at least some of the scope of the problem that then could demonstrate what the logjam is, why this difficulty can't just be worked out.

I haven't really heard a good reason why that can't happen. I am trying to work with you here. If we can see some instant savings, I would just like to see us follow through on it. That is all.

Dr. WINSHIP. I think there is no reason why that can't happen, to do such a study, to find out better information than we have. I will say that the phenomenon that you describe is one of the driving reasons for our efforts to convert hospital beds to nursing home beds, and we have a fairly major effort going on in that regard.

Mr. KENNEDY. I think that you might find that, with statistics like that that would demonstrate the phenomenon and back up the notions that we have, it might do a lot to alleviate the fears of VSO's and others that are concerned that there is a backwards plot to shut down every medical facility in the country that is so vitally needed.

So I just think that the more information we can get out about the scope of the problem, and the fact that there are ways to shift resources. And what we are trying to do is better serve the need of the veteran rather than shifting away from the kind of critical needs that currently exists, that you might be able to win more political support for the changes that you want to make as well.

Dr. WINSHIP. A very good point. Thank you, sir.

Mr. KENNEDY. So you will get us a study. Can we count on that, or what? What do you have to go through to find out what is going on?

Dr. WINSHIP. What I can promise you is that yes, we will address that; what I can't promise you is that by such and such a date I

will have all those data for you, because I don't know exactly how we need to go about that. That will take a fair amount of internal discussion.

Mr. KENNEDY. Well, maybe I can just ask the chairman what the best way to proceed is. If we can identify some savings, then it seems to me that that enables us to spend the dollars in a more efficient way.

What do you do?

Mr. EVANS. In terms of getting the information?

Mr. KENNEDY. Yes. Well, he is indicating that he is going to have a problem getting the study done. Then, if you don't get the study done, the problem just continues. I can see how we would slip into this for another year or a year and a half. You might be losing a couple of hundred million dollars a year or something like that to people who are sitting in these hospital beds that shouldn't be.

Mr. EVANS. You are reviewing the rate setting process at this time.

Dr. WINSHIP. Yes, we are.

Mr. EVANS. And do you know when that is going to be accomplished?

Dr. WINSHIP. By early 1991.

Mr. EVANS. Could we get quarterly reports from you in terms of the progress of that review and where you are going?

Dr. WINSHIP. You certainly can.

Mr. EVANS. Will that also include a review of the provider mix and 16 percent market share?

Dr. WINSHIP. That would be a separate review; those data are kept separately.

Mr. EVANS. That is going to occur, though. You indicated that you are going to take a look at the overall percentage, trying to raise that to 20 percent, and then also review the provider mix itself.

Dr. WINSHIP. We have carried out a number of internal discussions already about what that provider mix should be.

Mr. EVANS. That is not a study, that is just internal discussion?

Dr. WINSHIP. That is not a study that is going on, no. We have data, historical data, about the numbers and percentage of veterans that we do actually care for, and in comparison it indicates that the 16 is pretty conservative.

Mr. EVANS. Will the gentleman from Massachusetts please describe the report he is seeking? I was consulting with counsel.

Mr. KENNEDY. The point is that Dr. Winship acknowledges that there are patients in the VA today that are using acute care beds that, in fact, could be in nursing homes. The indication in Massachusetts, for instance, on this Medicare study, would indicate that that savings, just over the course of a few months, is over $85 million, so that the notion would be that there are lots of VA beds that are being used for acute care that could, in fact, be used where the patients could be moved out into nursing homes at a great cost savings and that that would enable us to either take in more acute care patients into the facility or to pay for the nursing home care.

Mr. EVANS. You are studying this at this time, Dr. Winship?

Dr. WINSHIP. No, we are not.

Mr. EVANS. You are not?

Dr. WINSHIP. Not in a systematic way.

Mr. KENNEDY. I wasn't blaming the doctor, but I was a little frustrated because he said it is going to be difficult for them to conduct the study and then it is going to be difficult for them to actually implement any changes. I am just showing a little frustration because although it is difficult for the doctor to order the study, it is also frustrating for us to just sit here, see the problem, and not see anything done about it.

Mr. EVANS. I would think that this should be considered part of the other studies in terms of trying to come up with a provider mix and the rate setting process. I think the VA should be studying this as well. If we are going to get a true picture, as the gentleman from Massachusetts is suggesting, on how we can reach veterans with the needed services that they require, but also save money so that we can help other veterans, I would think that this would be an integral part of what you are trying to accomplish.

I would request that you consider doing that as part of your study in terms of the rate-setting process, the overall mix, your discussions, and so forth, and perhaps provide us data on that. Is that doable?

Dr. WINSHIP. I think so, yes, sir.

Mr. EVANS. All right. Thank you. I thank the gentleman from Massachusetts for bringing that up.

Mr. KENNEDY. Thank you very much, Doctor. Thank you, Mr. Chairman.

(Subsequently, the Department of Veterans Affairs furnished the following information:)

Periodically, the Department surveys a sample of patients and has the nurse and social worker determine the appropriate location of care for the patients. The latest survey was conducted in August 1989. During that survey 7,535 patients in acute medical beds were evaluated. The survey found that 379 patients, or 5 percent, would be more appropriately placed in a nursing home. Of that group, the major reasons for continued hospitalization were:

27 percent remained hospitalized because a nursing home bed was not available or the nursing home was unwilling to accept the patient;

16 percent had no impediments to discharge and nursing home care was being arranged;

11 percent still required hospitalization on the day of the survey.

Mr. EVANS. Does the gentlewoman from Indiana have any questions?

Ms. LONG. I have no questions right now.

Mr. EVANS. I have a few brief ones. I think all of us will, of course, have additional questions to submit for the record, and those questions and the written responses by the witnesses will be made part of the official hearing record.

I understand that in the 1986 audit the IG found that in many instances those veterans who were in community nursing homes under all-inclusive contracts still had prescription medications being provided by the VA. That, I believe, was in the 1986 audit. Is that a practice that is still continuing? If it is, how is it that we allow those nursing homes to basically not pay those costs when it should be included in the all-inclusive contract that we have with them?

Dr. WINSHIP. That has been a problem in the past. I think we have dealt with that. Exactly where we are on that I'm not sure.

Dr. Yoshikawa, can you comment on that?

Dr. YOSHIKAWA. No, we haven't really looked at it carefully, so I can't really comment on that.

Mr. EVANS. Could you pull the microphone a little closer to you?

Dr. YOSHIKAWA. We haven't looked at it currently, so I can't tell you the exact status of that practice.

Mr. EVANS. Mr. Morani, you are doing another audit right now, aren't you? I assume this is going to be something that you will consider in your audit.

Mr. MORANI. Yes, Mr. Chairman, we are covering the 1986 audit as I mentioned in my testimony. We will evaluate whether those changes have been made and whether they are being complied with in the field.

Mr. EVANS. I would be very interested in knowing how we let these people out of the responsibility of providing prescriptions that should be included, I would assume, in that all-inclusive contract.

I don't know if anybody else has a comment on this. I would be glad to recognize them if they do. If not, I will recognize the gentleman from Florida for some additional questions.

Mr. JAMES. Thank you so much.

First, I want to thank the chairman for scheduling a hearing in my State, Florida, in June to go over some of the veterans' concerns that specifically relate to Florida. Thank you so much. I really appreciate it, and the veterans of Florida appreciate it. Hopefully, we will learn some additional information that will help us all in addressing some of the problems. And thank you for allowing me to interrupt your questioning, because I do have to go to another hearing that is scheduled in 5 minutes; I am vice chairman of that particular committee.

I want to, if I might, request to have permission to insert additional questions for the record.

Mr. EVANS. Without objection, it is so ordered.

Mr. JAMES. Thank you so much.

Mr. EVANS. I do have one final question I would like to ask. Which central office officials have community nursing home program responsibilities, and can you describe the central oversight of the contracting process?

Dr. WINSHIP. Dr. Yoshikawa has the immediate central office responsibility for the overall program and for programmatic aspects of the contracting process. Mr. Saldivar is the official responsible for all VA contracting programs. Mr. Harper here is more immediately responsible for the Contract Nursing Home Program.

Mr. Harper, do you have any comments about that question?

Mr. HARPER. I just might want to clarify our responsibility in that area. I am a part of VA's Office of Acquisition and Material Management. I report to Mr. Robert Saldivar, who is the Deputy Assistant Secretary for Acquisition and Material Management. That is an independent staff office. It is not part of the Veterans' Health Services and Research Administration.

We do, however, in the procurement, acquisition, and contracting area provide policy guidance, technical direction, and program oversight to the contracting activities that take place in VA medical centers.

Mr. EVANS. All right. Thank you. I thank the entire panel for testifying this morning and would appreciate your further follow-up on some of these issues we have raised.

[The additional questions appear on p. 57.]

Mr. EVANS. The members of our second panel are Mr. Robert Manhan and Mr. Phil Wilkerson.

Please come forward and be seated.

Bob is Special Assistant, National Legislative Service, Veterans of Foreign Wars. Phil is an Assistant Director, National Veterans Affairs and Rehabilitation Commission, the American Legion. This is the first appearance by Bob before our subcommittee. We want to welcome him and we will recognize him first.

Again, both of your statements in their entirety will be made a part of the record and you may summarize from them.

STATEMENT OF ROBERT MANHAN, SPECIAL ASSISTANT, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS

Mr. MANHAN. Thank you very much for that very warm welcome, Mr. Chairman. The VFW is very pleased to be here to participate in the important oversight hearing on the Community Nursing Home Program.

I would first comment on the VA IG reports. Regardless of what actions will or will not be taken this year, the VFW believes that the community nursing home feature must be retained as a necessary component of the veteran medical treatment and services for those veterans who need treatment other than acute medication.

We then have three recommendations: first, that Congress should take action to increase the fiscal year 1991 VA community nursing home budget request by at least the additional $96 million that you had already mentioned in your opening statement. The key thing from the VFW's point of view is that this will allow approximately another 10,000 veterans to be treated by the Community Nursing Home Program than would otherwise be possible.

The second recommendation we have is that both the House and the Senate Veterans' Affairs Committees should take action to pass legislation to mandate nursing home care treatment as a veteran's entitlement for the Category A patient. Our rationale is based on the philosophy that a continuum of health care should be provided.

Our third recommendation is that the VFW strongly supports the long-term nursing home care bed recommendation made in the Fiscal Year 1991 Independent Budget for Veterans. This was a joint activity that involved the VFW as well as three other nationally chartered veteran organizations. I want to quote from page 72 of that document. "For the long term, we propose that 500 VA nursing home beds be added to the VA system annually through the completion of four new 120-bed nursing homes each year in addition to the conversion of VA hospital beds." Those would be the acute beds. "Work on these new nursing homes must start now, since the last several budgets have not provided sufficient construction funds for nursing homes." Our fiscal year 1991 construction program budget proposes appropriations for these four homes. The cost was estimated to be $32 million.

Our rationale for wanting to have more in-house VA nursing home care is based on the philosophy that community nursing home care space may simply not be available to the VA-sponsored patient within the next few years. The previously stated VA goal of placing approximately 40 percent of the long-term geriatrics care veteran in the community nursing home assumes that the number of available community home beds will continue to increase to keep pace with the significantly aging American population. This, in fact, is not happening for a number of very complex social and economic reasons. Hence, it is reasonable to expect that any increase in the VA-sponsored community nursing home population is likely to displace an equal number of other patients. This will create strong resentments in the community.

To further compound this problem of a limited number of community nursing home beds, the cost of such care would obviously rise, thus involving the VA and Medicaid in a bidding war for the available space. The immediate loser, of course, is the Federal Government and the American taxpayer. The ultimate loser is the veteran.

It is also true that patients found in the VA nursing home units often are more severely disabled and require more intensive care and therefore more sophisticated facilities and/or sophisticated staffs than can be found in the private community nursing home sector. Or, stated another way, care provided in some portion of the community nursing home failed to meet even the minimum VA standards.

This concludes my statement. Thank you very much, Mr. Chairman.

[The prepared statement of Mr. Manhan appears on p 36.]

Mr. EVANS. Thank you.

Phil.

STATEMENT OF PHILIP R. WILKERSON, ASSISTANT DIRECTOR, NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION

Mr. WILKERSON. Thank you, Mr. Chairman.

We wish to commend you for conducting this timely and important hearing at a time when the availability of contract community nursing care services to veterans is decreasing throughout the VA medical care system.

Current Legion mandates urge VA to plan and develop a comprehensive health care program and related services for the aging veteran and to expand its role in the delivery of geriatric health care services. VA must maintain and further develop an adequate array of geriatric-related services to meet the growing and changing demands of our elderly veteran population.

The number of veterans 65 and older will rise from 6.7 million to some nine million in less than 10 years, and within the next 5 years the number of veterans 75 years and older will increase from 1.4 million to 2.6 million.

Contracting nursing home care is one of several important components of VA's overall extended care program. Under current policy, 40 percent of extended care is to be furnished in community

nursing homes with the remainder provided in VA's own nursing home facilities and State veteran homes.

In our statement, we cite VA work load data covering the last five fiscal years which show a steady increase in the number of patients treated in the various categories through fiscal year 1988 and then, last year, a very sharp decline in the work load totals. Mr. Chairman, we find these statistics to be alarming, particularly in view of the fact that there has not been a corresponding increase in either the State Nursing Home Care Program or in VA's own nursing homes. In the first 4 months of fiscal year 1990, the contract care program has been reduced another 1.6 percent.

Veterans' nursing home care, whether in a VA facility or contracted for within the community, is not a mandated service. Title 38 says VA may provide these services, which means that a veteran, service-connected or non-service-connected, does not have entitlement to this level of care, and as there is no statutory mandate, equity of access to this level of care has not been applied by VA.

Beginning in fiscal year 1989, VA medical facilities have had the flexibility to use community contract nursing home funds for other patient services that are mandated by law which has resulted in some facilities restricting placements to veterans with service-connected disabilities or utilizing substantially reduced contract stays from some 6 months to 3 months or even less.

Funding for the program for fiscal year 1990 was limited to fiscal year 1989 levels effectively, and even though additional funds were provided for the program in January of this year, it appears that hospital directors have not been increasing the level of community contract nursing home placements.

In our view, as long as this level of care remains discretionary there will be reluctance among medical center directors to utilize contract care funding for its intended purpose. The American Legion views this problem of providing for the aging veteran as one of the most serious facing the VA, and we believe that until a comprehensive plan to address this issue is developed certain segments of the veteran population will be underserved.

Community contract nursing home care is a vital component in VA's overall approach in providing long-term care. Funds cannot be continually diverted and still meet the long-term care needs of the veteran community. Sequestration and other factors in the current year have forced VA to reduce program funds. We feel very strongly that there is a need to restore funding to at least fiscal year 1988 levels.

In conclusion, Mr. Chairman, we believe that many veterans today are receiving neither adequate nor fair treatment in the provision of VA long-term health care services. The American Legion encourages the subcommittee to conduct a full review of this critical issue.

That concludes our statement, Mr. Chairman.

[The prepared statement of Mr. Wilkerson appears on p. 39.]

Mr. EVANS. Thank you.

As you have heard and most people know, the current mix of services is about 40 percent for the community nursing home program, VA nursing homes account for 30 percent, as do the State nursing homes. Should there be changes in this mix? I understand,

Mr. Manhan, that you basically feel that we should be building more VA Nursing Home Care Units. What would be the percentages we should be looking at as targets as we approach the year 2000?

Mr. MANHAN. Mr. Chairman, I would suggest that we should start increasing the 30 percent VA nursing home care from its present level to, by the year 2000 or 2010, something like 60 or 70 percent.

Mr. EVANS. And then the two other components making up the difference?

Mr. MANHAN. Yes. I think it is reasonable to assume that any Federal agency must have a safety net or some way to take care of those patients or those constituents that need something that the Government itself cannot take care of in-house. Then it would become probably a dollar driven issue, whether it is State nursing homes, veteran nursing homes, or community nursing homes that would be more cost effective.

Mr. EVANS. Phil.

Mr. WILKERSON. Mr. Chairman, the American Legion has not made a thorough-going analysis of what VA's total program should be comprised of. I think we will be taking a close look at this in the very near future. However, I would support the VFW's position that VA certainly can and should increase the proportion of nursing home care provided in-house. I would not at this juncture care to speculate as to what the percentage might be. I believe one of the critical factors would be what would be the most cost-effective mix, and this should certainly be one of the primary issues to be addressed in VA's comprehensive plan to meet the needs of the aging.

Mr. EVANS. You heard the VA announce today they would like to raise the 16 percent figure in terms of reaching veterans who need nursing home care to 20 percent. Is this goal going to be adequate, in your opinion, as the veterans population grows older?

Mr. MANHAN. Mr. Chairman, I really don't think it is going to be adequate, because we don't know how many veterans would take advantage of the nursing home care program if it were available to them, or, said another way, if they were entitled to it.

I believe Dr. Winship tried to come to grips with that in two or three different ways. Until you know what constituency you have, I guess you can't put any absolute figure on it, but, percentage-wise, perhaps 60 percent is as good as anything to start with.

Mr. EVANS. Phil, in your testimony, you call on the VA to change the configuration of its services during the next decade and provide the services needed by a larger number of older veterans. What would be that change, in your opinion, that is needed?

Mr. WILKERSON. I think part of it certainly depends on research into more specifically identifying the needs and the appropriate types of services that will be required for those that come to the VA seeking treatment, those eligible veterans, and, depending on appropriate level of funding, there needs to be an increased commitment towards expanding both the acute and long-term aspects of VA care. I don't have any more specific comments in that area.

Mr. EVANS. Thank you.

Does minority counsel have any questions?

Ms. ALVARADO. No, thank you.

Mr. EVANS. If not, thank you both for your testimony. We appreciate your time today.

Our final witnesses today are representing Manor Care, Incorporated. The members of this panel are Mr. Schmitt, who is accompanied by Mr. Robert Bernhardt.

Please come forward and be seated.

Mr. Schmitt is Vice President of Operations, Southeast Division; Mr. Bernhardt is the Assistant Director of Reimbursement.

We welcome you. I don't know if you have testified before our committee before, but we are glad to hear from you. You may summarize from your statement that you have submitted to us. We will include your entire statement in the record.

STATEMENT OF JOSEPH SCHMITT, VICE PRESIDENT OF OPERATIONS, SOUTHEAST DIVISION, MANOR CARE, INC., ACCOMPANIED BY ROBERT BERNHARDT, ASSISTANT DIRECTOR OF REIMBURSEMENT

Mr. SCHMITT. Thank you very much. Manor Care appreciates the opportunity to present our perspective on the challenges facing you in meeting the nursing home needs of America's veterans.

As was mentioned earlier, my name is Joseph Schmitt, and I am vice president of operations for Southeast Division, Manor Care. We are proud of our record as a contractor under the VA Community Nursing Home Program. In addition, we are a leading provider of nursing home care with 157 facilities in 28 States.

I want to offer you an operations perspective about the potential and the realities of the VA Community Nursing Home Program. Also, I want to focus your attention on the needs of the 84 percent of the veterans who need nursing home care but who must get it outside any of the three VA programs.

The committee, the veteran service organizations, and the Department have done a thorough job on planning for the increasing number of aged veterans. Our concern, simply stated, is that enough of the right things are not actually being done to meet nursing home care objectives. The "age wave" is about to swamp the Government's political willingness to fund and the Nation's structural capacity to provide long-term care.

Chart 1, located at the end of my written statement, shows the patient days since 1980 for each of the three provider formats. As you know, VA intends to serve only 16 percent of the veterans who need nursing home care. I call your attention to the budget-induced drop in VA's utilization of community homes since 1988.

Chart 2 shows the trend in the percentage utilization of community nursing homes. The objective of 40 percent utilization of community facilities has never been achieved, and that shortfall is increasing. The percentage has dropped since 1985 and next year is budgeted to be 28 percent. Like other VA contractors, we have had to reduce our amount of service under the Community Nursing Home Program.

To meet VA's target for community nursing homes, the census will have to increase by 104 percent by the year 2000. We both need to know either how VA will accomplish such a turnaround,

especially with pressures to cut reimbursement, or how other programs will be increased to compensate.

For the Community Nursing Home Program to ever make the 40 percent level, problems about the period of coverage and reimbursement rates must be addressed.

Regarding coverage, there are wide variations in periods of coverage for non-service-connected care. In most localities, coverage has become a transitional benefit until Medicaid takes over. The principal reason for declining utilization is VA's efforts to arbitrarily control reimbursement through the levels adequate to provide quality care and attract a sufficient share of scarce beds.

Generally, VA payments have increased 3 percent a year for the last 3 years, while our average company costs have increased 6 percent. Rapid cost increases are attributable to higher labor costs and newly imposed regulations to improve the quality of care. A scarcity in the bed supply has also prompted a natural triaging of patients, resulting in a greater intensity of services and the average cost of care.

For purposes of this hearing, we have attempted to assess the direct cost of patient care and the corresponding reimbursement levels. Our average costs for patient care range across our five regions from $68 to $90. Our current VA contract rates for skilled care range from $57 in Fort Worth to $93 in the D.C. and Chicago areas. Our intermediate care rates range from $42 to $86 in these same cities. For comparable patients, VA reimbursement is approximately 10 to 12 percent below our private pay rates and 44 percent less than our average medicare rates.

VA currently limits reimbursement to the Medicaid rate plus 10 to 15 percent. The Medicaid rate is a totally inappropriate basis of payment because States typically under-fund this program, making it a function of the State budget. Rates range from $40 in Texas to $75 in Florida. Medicaid methodologies can also vary from a flat rate in Oklahoma to a case mix system in Maryland. These variations contrast sharply with the facility-specific, predetermined, all-inclusive rate which VA offers.

Simply, if we are to continue to offer high-quality services for our veteran population, we need the Federal Government to support our efforts through the reimbursement system. Mindful of the budgetary constraints, we recommend your consideration of the following two approaches which would improve the Community Nursing Home Program's effectiveness and attractiveness:

One, eliminate the all-inclusive rate which is based on the Medicaid system. Reimbursement guidelines should be set in some relation to Medicare reimbursement rates and methodology. For example, VA could adopt a rate calculation formula that is similar to the medicare prospective payment option for nursing homes to cover routine costs of operating expenses, including nursing, dietary, laundry, housekeeping, et cetera. Special services would be paid on a normal fee-for-service basis. Such a methodology would be advantageous, because it would account for variations in regional and local market conditions.

Two, incorporate specific incentives into the VA reimbursement methodology for desired outcomes. For example, reimbursement for those patients requiring special kinds of service, such as tube feed-

ing or sub-acute rehabilitation, could be segregated out of the all-inclusive rate and paid under a separate classification system. Such incentives would be particularly useful in helping to place heavier care patients. It is our understanding that a few State Medicaid programs already offer enhanced rates for special levels of care.

Every resident is entitled to high-quality nursing care and related services. However, nursing home care is more than a service, it is a life style. Veterans and their families should have the widest possible range of choice in their living and care arrangements.

Before closing, I would like to address increasingly serious infrastructure needs for nursing home care. Projections by the VA indicate that the number of veterans requiring long-term care by the year 2000 will top 290,000. VA expects to provide care to 16 percent, or 46,000 patients. But what about the remaining quarter-million veterans? Where will those people find adequate institutional care in the wake of severe bed shortages?

Expansion in the number of beds is not keeping up with increases in the age population, and the growth in demand will increase about twice as fast as the recent construction trend. Charts 3 and 4 show the supply and demand trends.

The long-term care industry needs capital investment of almost $34 billion for new facility construction by the year 2000, not including the large capital needed for renovating or replacing old facilities. Without the infusion of new capital, the capacity to provide long-term care for our growing veteran population and all elderly persons will be jeopardized.

We appreciate the opportunity to testify before you today. We would like to encourage the adoption of a uniform, nationwide application of long-term care benefits to ensure fairness and equity among all veterans. We also would like to see modifications in the reimbursement system to foster greater private sector involvement.

The Community Nursing Home Program is currently under-utilized, and we would like to work with you and the VA to increase proper participation. Thank you very much.

[The prepared statement of Mr. Schmitt appears on p. 44.]

Mr. EVANS. Thank you, Mr. Schmitt.

According to your statement, the supply of nursing home beds is not increasing as fast as the need for care and, "One consequence is the natural triaging of patients, resulting in a greater intensity of services and the average cost of care." I am not sure I quite understand that. Can you explain to me how are patients being triaged? On what basis? Is it on the basis of need or the amount which can be paid?

Mr. SCHMITT. Both. The care need of the patient makes it very difficult for the VA hospital to place them in a nursing center. What makes it difficult is, not many facilities that have contracts with VA have the capability of taking an extremely high acuity level type patient, and the other part is, if they do, they also know that the cost of caring for that patient is extravagant. So it is on both sides.

Mr. EVANS. There has been, I understand, a 50 percent reduction in the number of Manor Care nursing homes which participate in the VA program during the last 3 years, from 80 to about 40 facilities.

Mr. BERNHARDT. The number of patients, Mr. Chairman.

Mr. EVANS. The number of patients, and that would be mostly explained by the problems you are having?

Mr. SCHMITT. Yes, sir. We have 60 facilities that participate in the program; 20 facilities are inactive right now, do not have any veteran patients.

Mr. EVANS. Please repeat that?

Mr. SCHMITT. Twenty do not have any veteran patients.

Mr. EVANS. How many, then, do participate in the VA program in your chain of nursing homes?

Mr. SCHMITT. How many facilities?

Mr. EVANS. Yes.

Mr. SCHMITT. Sixty.

Mr. EVANS. And that number is still decreasing at this time, or has it stabilized?

Mr. BERNHARDT. That number is decreasing, Mr. Chairman, as a result of the all-inclusive Medicaid rate primarily. The Medicaid rate is a cost formula, but it does not recognize all the costs associated with the treatment of our patient population, and, as a result of that, the VA rates are tied on to that and we are not getting the proper rates. People are reluctant to take the sicker patients.

Mr. EVANS. Is your company providing nursing home care on a profitable basis to Medicaid patients?

Mr. SCHMITT. I would say, in general, no.

Mr. EVANS. Can you tell us, perhaps, what your earnings might have been to your company for providing care last year to Medicaid patients? Was it a loss?

Mr. BERNHARDT. That would be difficult, Mr. Chairman. Our costs for our company are approximately $77 per day. The Medicaid program, on the average, reimburses us $55 a day.

Mr. SCHMITT. Supplemented by the private pay sector.

Mr. EVANS. Do your patients paying a per diem rate, higher than Medicaid, receive a higher quality of care than those who pay less?

Mr. SCHMITT. No. If we accept a patient in our facility, they are going to receive the best that we can offer.

Mr. EVANS. How many of your homes have been asked by the VA medical centers that have jurisdiction over them for this program to provide pricing data or document costs?

Mr. BERNHARDT. During the rate negotiation process now, Mr. Chairman, all of them do, and we are able to provide that data to them because we changed our accounting system to provide that.

Mr. EVANS. Would you agree with some of the veterans' organizations who have testified that it is more costly to provide services to veterans because they often require more sophisticated care because of disabilities? Has that been a problem you have seen?

Mr. SCHMITT. I don't know that it has been a problem, but it requires more sophisticated techniques. I think one of the things that we would like to see is more rehabilitative programs being offered. These are expensive, such as physical therapy, occupational therapy, and related type programs. Under an all-inclusive rate, though, that becomes extremely difficult.

Mr. EVANS. Does minority counsel have any questions?

Ms. ALVARADO. No, thank you.

Mr. EVANS. Thank you very much. We appreciate you raising these issues as private providers. We may have some additional questions for you. We will submit those to you and ask that you provide written responses, which will also be included as part of the record.

Mr. SCHMITT. Thank you, Mr. Chairman.

Mr. EVANS. Thank you.

There being no other business before the subcommittee, we stand adjourned.

[Whereupon, at 10:20 a.m., the subcommittee was adjourned.]

APPENDIX

STATEMENT OF

RENALD P. MORANI

ACTING INSPECTOR GENERAL

DEPARTMENT OF VETERANS AFFAIRS

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON VETERANS' AFFAIRS

OF THE

U.S. HOUSE OF REPRESENTATIVES

MARCH 28, 1990

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss selected aspects of the Office of Inspector General's coverage of the Department's contract community nursing home care program. In keeping with the objectives of this hearing, I would like to focus my remarks on the audits our office has performed that have addressed community nursing home contract costs.

Community nursing home care was authorized by Public Law 88-450 on August 19, 1964. The law authorized VA to transfer veterans needing nursing home care to community, or non-VA facilities, instead of providing them similar care in VA hospitals that would cost more than community nursing home care. The law was passed to reduce the number of hospitalized veterans in VA hospitals who no longer required acute care, and instead needed a convalescent period in a nursing home that otherwise would not be available to them.

Community nursing home contracts are to be established with nursing homes that meet VA standards and evaluation criteria. Contracts are usually awarded for two levels of nursing home care, skilled and intermediate. VHS&RA expects contract rates to be based on

Medicaid rates approved by states for nursing homes, and actual cost data. Existing VHS&RA policy requires that VA medical centers use Medicaid rates as general market values of nursing home care in their communities. If Medicaid rates are not considered as reliable market values, contracting officials are to use financial data from nursing homes to determine if proposed contract rates are reasonable and justified.

VA patients occupied less than 2 percent of the total beds in contracted facilities. VA had about 3,900 contracts as of June 30, 1989. The 3,900 VA contracts had contract rates for about 3,100 skilled and 3,200 intermediate care facilities. The contract homes had a total of about 224,700 skilled and 182,400 intermediate care beds. Total VA patients in skilled beds was about 4,000 and 3,100 in intermediate beds.

Costs for the community nursing home program rose steadily from $281 million in FY 1986 to $322 million in FY 1988. Because of budgetary constraints, about $251 million was expended in FY 1989. The average cost of care ranged from about $63 a day in FY 1986 to $74 in FY 1989. There were about 32,000 VA patients treated in the community homes in FY 1989, representing an average daily census of about 9,000. VA expects the average daily census to double to 18,000 by FY 2000.

Community nursing home contract procedures have been identified by VA as a material weakness in their most recent submission under the Federal Managers Financial Integrity Act. This situation is currently under review by the Senior Management Council.

The Office of Inspector General has reviewed the contract community nursing home care program through national and medical center audits with emphasis on the cost of such contracts. In 1986, we performed a national audit of contract rates for community nursing

home care (Report No. 6R6-A07-151, dated September 30, 1986). The audit identified that an estimated $61 million annually could be made available for other veteran health care needs if VA medical centers negotiated rates for community nursing home care based on Medicaid rates plus actual costs for additional services not covered by Medicaid. The Chief Medical Director and the (then) Director of the Office of Procurement and Supply concurred with the audit recommendations, and agreed to issue clarified policies and procedures. The Chief Medical Director also agreed to issue a policy requirement that periodic market surveys be conducted by VA medical centers, to help increase competition among nursing homes they may establish contracts with. Policy changes were published in revised policies issued in July 1988.

Since that audit report was issued, the Office of Inspector General has identified in 24 facility audits during FY 1987 through the first quarter of FY 1990 continued weaknesses in the contract negotiation process for obtaining community nursing home care. The facility audits showed that about $7 million annually at the 24 medical centers could be used for other health care needs if medical centers complied with Agency policy requirements to use Medicaid rates and actual cost data as a basis for awarding contracts.

Our audits continue to show that contract negotiation procedures needed improvement for two main reasons: (i) contracting officers were not using Medicaid rates to negotiate prices for contract care; and (ii) they also did not obtain supporting cost data from nursing homes to justify awarding rates that exceeded Medicaid rates plus a 15 percent supplement for all-inclusive services.

In view of the repeated findings in the contract negotiation process, along with continued increases in daily costs of contract care, we recently initiated a national audit to: (i) followup our 1986 audit report; (ii) summarize the results of the 24 medical

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center audits; and (iii) evaluate the current situation nationally and at selected sites. We wanted to determine if and why VA medical centers continue to have difficulties in establishing reasonable contract rates and the problems the centers had in the contract negotiation process. Medical Center management expressed a desire to obtain the nursing home care at an economical price, but found it difficult to implement a fully economical program at each site. We have not finalized our summation of this audit, but can offer the following concerns at this time:

- Effective compliance by contracting officials with VHS&RA policy on using Medicaid rates or actual cost data, as the basis for awarding contracts.

- Sufficient understanding by contracting officials of the structure of Medicaid rates to determine whether those rates truly reflected market values of nursing home care in their communities. Some Medicaid rates included profit to nursing homes, yet those homes' administrators may inform contracting officials that the Medicaid rates do not cover their costs of operations and are too low to use as a basis for contract negotiations. We obtained information from 163 VA medical centers and other facilities that showed only 66 (40 percent) had previously contacted states to discuss nursing home Medicaid rates for use in negotiating contracts.

- VA contracting officials typically are not in a strong negotiating posture as noted by the fact that less than 2 percent of contracted facilities' beds are occupied by VA patients.

- Agency policies have been oriented to paying for costs of care, while nursing homes are profit-oriented.

- VA often authorized short-term nursing home contract periods for veterans, while many nursing homes are primarily long-term care facilities. Nursing home administrators informed us that

the initial period of care was the most expensive to them. As patients were stabilized and rehabilitated, costs of care gradually decreased.

- Finally, a need for an effective oversight system that would help ensure contracts are awarded in the most efficient, effective and economical manner.

In summary, our review of the community nursing home care program continues. At this time, it appears that Agency policy and procedures may require change to have VA medical center contracting personnel use financial or cost report data as the primary basis for determining reasonable contract rates, instead of Medicaid rates. Also, guidelines for determining acceptable profit margins for community nursing homes may need to be developed. Additionally, improvements in internal controls would be in order to strengthen compliance with policy and procedures to include a better reporting system that would allow central oversight and coordination of facility contracting. If the large increase in contract nursing home care projected for FY 2000 is accurate, effective procedures and controls must be put in place now to ensure the needed care is obtained in the most cost efficient manner.

Mr. Chairman, this concludes my statement. We will be pleased to answer any questions that you may have.

STATEMENT OF

DANIEL H. WINSHIP, M.D.

ASSOCIATE DEPUTY CHIEF MEDICAL DIRECTOR

VETERANS HEALTH SERVICES AND RESEARCH ADMINISTRATION

DEPARTMENT OF VETERANS AFFAIRS

BEFORE THE SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

COMMITTEE ON VETERANS' AFFAIRS

HOUSE OF REPRESENTATIVES

MARCH 28, 1990

Mr. Chairman and Members of the Subcommittee:

It is a pleasure to appear before this Subcommittee to discuss the Department of Veterans Affairs' Community Nursing Home Program.

PROGRAM POLICY

The Community Nursing Home Program (CNH) was established by Public Law 88-450 in 1964. It is one of three VA-sponsored programs providing nursing home care; the others are the VA-operated nursing home care units and the State Home Program. Through the CNH Program, VA contracts with 3,400 nursing homes across the country and treats the largest number of veterans, 32,000, of the three programs.

The purpose of the CNH Program is to provide needed nursing home care to patients in making the transition from hospital care to community living or to allow time for the patient and family to make other arrangements for continued care. A nonservice-connected veteran may be placed in the CNH Program at VA expense if the veteran needs nursing home care following an episode of VA hospital care. Service-connected veterans, needing nursing home care for their service-connected disability, may be placed directly from the community. By law, patient placements for nonservice-connected conditions may not exceed six months. These placements may be extended for 45 days under certain circumstances. Placement for a service-connected condition or placement of a patient whose hospitalization was primarily for a service-connected condition, may be made for as long as nursing home care is needed.

GUIDELINES AND ADMINISTRATION

VA contracts only with licensed nursing homes which meet VA standards for patient care, staffing levels and fire safety, among others. VA accepts Medicare/Medicaid nursing home standards as its own with two exceptions. First, VA requires that nursing homes meet the most recent edition of the Life Safety Code, established by the National Fire Protection Association. Second, for Intermediate Care Facilities (ICFs), VA requires licensed nursing coverage (RNs or LPNs) at all times.

Before VA enters into a contract with a nursing home, an interdisciplinary team reviews the latest Medicaid report from the State and, based on the deficiencies found by the State surveyors, determines which team members are required to visit the home. Evaluations are conducted annually thereafter. The team is normally composed of a physician, nurse, social worker, dietitian, pharmacist and the fire safety officer. If no deficiencies were found by the state surveyors, the nurse and social worker will visit the home to assess the quality of care and the quality of life in the home and the special features of the home for treating veterans. VA does not regulate nursing homes, but contracts only with nursing homes that meet VA standards.

In addition, each VAMC provides monthly follow-up visits to veterans in the CNH Program by a social worker and/or a nurse. The visits are designed to identify and resolve any health or post-placement issues; help to smooth the transition to the nursing home environment; and to provide guidance to the nursing home staff in meeting patients' needs.

CONTRACT CARE COSTS

VA spent $281 million for the treatment of over 32,000 veterans and program support in the CNH Program in FY 1989. The FY 1990 budget included $286 million for program support and treatment for approximately the same number of patients. The estimated per diem rate for FY 1990 is $77.96. The CNH per diem rate is 44 percent less than the VA nursing home per diem. The President's Fiscal Year 1991 budget includes $300 million for the CNH program. Over the past six years, per diem rates have increased an average of 6 percent per year. These increases have been the result of inflation, greater market

penetration in high cost-of-living areas, and, to a lesser degree, expanding the program to care for heavy care and higher cost patients, such as chronically ventilator-dependent patients.

CONTRACT RATE NEGOTIATIONS

In establishing contract rates with nursing homes at the local level, VAMCs are instructed to negotiate an all-inclusive rate, covering all nursing home services. Medicaid, the largest payor for nursing home care, covers room, board and general nursing care; therapies, medical services and drugs are billed separately. Medical centers are directed to use the home's Medicaid rate as a basis for negotiations and add up to 15 percent more to cover the all-inclusive nature of VA's contract. Where Medicaid rates are not a reliable indicator of actual cost, or where the proposed rate exceeds the Medicaid rate by more than 15 percent, nursing homes must provide documentation to justify a higher rate.

The VA is reviewing its approach to CNH rate setting. This is an extremely complex subject and one that will become even more complex with the elimination of the distinction between Skilled and Intermediate levels of care in October 1990. We anticipate that we will provide additional directives on this subject within the next eighteen months. In the meantime, medical centers have the flexibility they need to negotiate properly justified rates that reimburse homes for their costs.

VA works to secure quality nursing home care for veterans in their communities at a fair price. We want to maintain our good relationships with nursing homes. We are not, however, in a particularly strong position in negotiating rates. The CNH Program accounts for less than one percent of all nursing home expenditures in the country so nursing homes do not need our business. This is especially true in this industry where occupancy rates exceeding 90 percent nationwide and exceed 95 percent in major metropolitan areas.

IG AUDITS

In addition to our concern about the adequacy of the rate setting policy, VA's Inspector General (IG) has examined the process of rate setting during a

number of recent cyclical audits. The IG has identified an issue of non-compliance with the "Medicaid plus 15 percent" policy at some medical centers. Audits have found that, in some cases, there was insufficient documentation to justify rates above what the policy would indicate. In other cases, the IG found that medical center staff did not have sufficient (and in some cases any) cost information to determine whether VA's contract rate was closely related to the cost of care. The IG is currently conducting a national audit on this subject.

The Department has responded to the audit findings. We have changed and strengthened the policy manual on rate negotiations, offering detailed instructions on rate setting. We have conducted two nationwide teleconferences on the subject and held workshops at a national conference. As we mentioned above, we will provide additional directives following our review of the entire rate structure.

FUTURE DIRECTION

The Department expects the CNH Program to grow in the future in keeping with our overall nursing home policy for 2000 and 2005. In this year, it is VA's goal to provide care for 16 percent of the total veterans expected to need nursing home care. It is also the Department's goal to provide 40 percent of that care through the CNH Program; 30 percent of the care through the VA Nursing Home Care Units; and 30 percent through the State Home Program.

SUMMARY

In summary, the CNH Program is an essential component of VA's nursing home care program. Significant growth in this program is projected as a major part of our plans to meet the future needs for nursing home care. We believe the program is well managed both nationally and locally. Audits have identified the need to better document rate setting decisions in certain instances, and we will follow-through to be sure this is done.

Mr. Chairman, this concludes my remarks. I shall be pleased to answer any questions you or members of the Subcommittee may have.

STATEMENT OF

ROBERT MANHAN, SPECIAL ASSISTANT
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO

REVIEW THE COMMUNITY (CONTRACT) NURSING HOME CARE PROGRAM

WASHINGTON, D. C. MARCH 28, 1990

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

The Veterans of Foreign Wars of the United States (VFW) is pleased to take this opportunity to present its views on an issue that relates to the health care requirements of our nation's aging veteran population. It is my privilege to represent the 2.8 million members of the VFW. This figure includes the 700,000 members of our active Ladies Auxiliary who are very interested in the general topic of the Department of Veterans Affairs' (VA) long-term nursing home care programs.

The purpose of the Community Nursing Home (CNH) program is to assist veterans and their families to make the transition from an episode of hospital care, nursing home care, or domiciliary care to a community living pattern. For many, placement represents an interim period of care pending completion of arrangements to return to their own homes, community residential care facilities, or homes of relatives or friends. Others may need to remain in the nursing home indefinitely on a long-term care basis.

The general thrust or outline of this statement is to first highlight some pieces of key long-term nursing home care information and then to outline both immediate and future VFW recommendations.

BACKGROUND FACTS:

The Community Nursing Home program (CNH) under review today is one of three VA nursing home programs. The others are the in-house Department of Veterans Affairs Nursing Home (VANH) and the Veteran State Nursing Home (VSNH) programs. The primary goal of all nursing home programs is to maintain or restore the veteran to the highest level of health and well-being attainable. VA's approved plan to meet the long-term care needs of our aging veteran is to provide some degree of assistance or support to only 16 percent of the estimated 290,400 veterans who will need such care by the year 2000. It is predicted these fortunate 46,464 veterans will receive care in the following percentages by nursing home programs in the year 2000:

30 percent in VANH
40 percent in CNH (This is the only program under review today.)
30 percent in VSNH

It is also a fact nursing home care is not mandated by law, as is acute care hospitalization for certain veterans. This explains, to some extent, the previously mentioned overall planning figure of funding a 16 percent goal.

The CNH program was established in 1965 by Public Law 88-450. Today VA contracts with about 3,600 community homes across the nation. In FY 1988 CNH treated 42,232 patients at a VA cost of $348,504,000. Information available to the VFW indicates in FY 1989 CNH treated 32,209 patients at a VA cost of $250,000,000. VA is presently projecting a FY 1990 patient case load of about 31,500 patients at the same cost of $250,000,000. For FY 1991 VA is requesting $272 million to treat about 31,500 patients.

The next fact to consider is the demographics of the veteran population with the emphasis on its size, density, distribution, and age. Over the last 11 years, or since 1979, the number of aged veterans has doubled, while the overall number of veterans will steadily decline from 27 million down to 17 million over the next 30 years. At the same time the number of aged veterans, those 65 years of age and older, will continue to increase from slightly over seven million to almost eight million, peaking in the year 2000 at approximately nine million elderly veterans. More than four million of these veterans will be over the age of 75.

And last are the present eligibility requirements. Veterans hospitalized for a service-connected condition or who need nursing home care for a service-connected condition may be placed in a CNH at VA expense for as long as they require that level of care. Veterans with nonservice-connected disabilities may be placed in a CNH at VA expense for a period of time not to exceed six months, following an episode of care at a VAMC.

OVERVIEW OF VFW CNH PHILOSOPHY:

While we have no specific resolution dealing with community nursing home care we believe in the principle of having the VA maintain a broad-based, fully funded, active strategy to meet long-term nursing home care needs of our elderly veteran population. However, the VFW places the greatest weight on converting VA acute hospital beds to in-house nursing home beds and to fund the construction of new VA nursing home facilities.

The VFW also recognizes the VA's need to gradually expand the contracting programs with particular emphasis on the CNH to act primarily as the "safety net" to accommodate more veterans than would otherwise be possible within the VA and the Veteran State Nursing Home programs. Along with these essentials we add the need for an expanded VA geriatrics medical program and an immediate series of VA planned initiatives to address non-institutional programs that make greater use of other than nursing home resources within the community for elderly veterans.

The above points are reinforced by a review of 15 different VA Office of Inspector General (IG) reports. All focused on the problems associated with contracting for CNH services. These reports covered the four year period of time from October 1985 to June 1989. Each report dealt with the audit of a specific VA medical center. For example in 1989 the facilities in Gainsville, Florida; Chillicothe, Ohio; and Louisville, Kentucky, were audited and more than one million dollars were identified as having been misspent by those three centers for CNH care. A number of different, but well-documented reasons were cited. Based on these reports the VFW believes that if writing and executing proper CNH contracts is a serious enough problem in the overall scheme of VA business, then some corrective action should be taken this year. Our judgment is based on the obvious conclusions that contracting problems have been identified almost everywhere in the system, in great detail, and over a reasonable period of time to expect the same deficiencies to continue. Regardless of what action(s) is or is not taken as a result of these collective IG reports, the VFW strongly holds to the position the CNH feature must be retained as a necessary component of veteran medical treatment and service. Again, the best course of action is to expand the VA in-house nursing home facilities.

IMMEDIATE RECOMMENDATIONS:

The Congress should take action to increase the FY 1991 VA CNH budget request at least an additional $96 million from $272 million to $368 million. This figure will restore the CNH funding to the 1988 level (to include the inflation factor) and allow 10,000 more veterans to receive care than is presently planned for; that would be 41,500 veterans. In fact this position was taken on February 28, 1990, by the House Veterans' Affairs Committee, an action the VFW very much appreciates and one we actively support, when it called for a seven percent increase in the FY 1991 VA budget. The rationale for this action demonstrates the committee's continuing recognition of the decremental budget reductions in the VA medical care program over the past several years. As we all recall this resulted in forced closure of hospital beds, reductions in and curtailment of certain treatment programs, elimination of treatment for many nonservice-connected veterans and contracts with community nursing homes being reduced from six months to a period of 90 days or less.

We also ask that both the House and Senate Veterans' Affairs Committees take action to pass legislation to mandate nursing home care treatment as a veterans' entitlement for the Category A patient. Our rationale is based on the philosophy that the continuum of health care should be provided by law for Category A patients. This group includes service-disabled veterans, ex-POWs, veterans of WW I or earlier conflicts, veterans exposed to ionizing radiation and Agent Orange, VA pension recipients, and veterans with Medicaid and other low-income veterans. This recommendation is directly supported by VFW Resolution Number 691 "Guaranteed Entitlement to Nursing Home Care" for those entitled to inpatient care. This same philosophy is also expressed in the Fiscal Year 1991 Independent Budget for Veterans Affairs. Because these veterans are already entitled to inpatient acute medicine, surgery, and ambulatory care, the next logical step should be long-term care, to keep pace with their geriatrics needs.

RECOMMENDATIONS FOR THE FUTURE:

VA should plan, fund and develop a more extensive array of in-house services for the expanding aging veteran population. It is the VFW's position that VA should not escape its responsibilities to all older veterans by merely writing a check to the CNH program to care for a very few on a discretionary basis.

We strongly support the long-term nursing home bed recommendation made in the Fiscal Year 1991 Independent Budget for Veterans Affairs. As you recall this was a combined effort of the VFW and three other nationally chartered veterans' service organizations. The following proposal is taken from page 72 of this document which deals with the topic of future veteran needs.

> "For the long-term, we propose that 500 VA nursing home beds be added to the system annually, through the completion of four new 120-bed nursing homes each year, in addition to conversions [of VA hospital beds]. Work on these new nursing homes must start now, since the last several budgets have not provided sufficient construction funds for nursing homes. Our FY 1991 Construction Programs budget proposes appropriations for four nursing homes."

The Independent Budget recommends $32 million as a major construction effort, to build four 120-bed nursing homes. This action is in keeping with VFW Resolution Number 631 "To Provide Adequate VA Health Care Budget" for our veterans' future health care needs, and Resolution Number 634 to "Adequately Fund the Veterans Health Care System Construction Program." A copy of all resolutions mentioned are attached to this statement.

Our rationale for this four new VA 120-bed nursing homes construction effort is to call attention to the fact that CNH space may simply not be available to the VA sponsored patient within the next few years. The previously stated VA goal of placing 40 percent of long-term geriatrics care veterans in the CNH assumes that the number of available community home beds will continue to increase to keep pace with the significantly aging American population. This in fact is not happening for a number of very complex social and economic reasons. Hence, it is reasonable to expect that any increase in VA sponsored CNH population is likely to displace an equal number of other patients. This surely will create strong resentments in the community. To further compound this problem of a limited number of CNH beds, the cost of such care would obviously rise; thus involving the VA and Medicaid in a bidding war for space. The immediate loser is the federal government and the American taxpayer; the same person I am now asking to fund a larger VA construction budget! The ultimate loser, however, is the veteran. But there is no doubt that VA construction is costly.

It is also true that patients found in the VA nursing home units often are more severely disabled and require more intensive care and therefore more sophisticated facilities and staff than can be found in the private CNH sector. Or stated another way, care provided in some portions of the CNH area fails to meet even the minimum VA medical standards. All these factors make a strong case for more VA in-house geriatrics long-term care facilities.

This concludes my statement. I will respond to any Committee questions. Thank you Mr. Chairman.

STATEMENT OF PHILIP R. WILKERSON, ASSISTANT DIRECTOR
NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION
BEFORE THE SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
COMMITTEE ON VETERANS AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
MARCH 28, 1990

Mr. Chairman and Members of the Subcommittee:

The American Legion welcomes this opportunity to presents its views on the subject of contractual nursing home care provided veterans by the Department of Veterans Affairs.

Mr. Chairman, we commend you for conducting this timely and important hearing at a time when the availability of contract community nursing care services is decreasing throughout the VA medical care system.

At The American Legion 1989 National Convention held in Baltimore, Maryland, the delegates approved resolutions No. 301 (AZ) and No. 303 (AZ), to urge VA to plan and develop a comprehensive health-care program and related services for the aging veteran, and to expand its role in the delivery of geriatric health-care services. We believe VA must maintain and further develop an adequate array of geriatric related services to meet the growing and changing needs of our elderly veteran population.

Contract community nursing home (CCNH) care is one of several important components of VA's overall extended care program. To help meet the overall need for VA nursing home care, we believe this program must be expanded in future years to meet a growing need for community-based care.

Current VA statistics project the population of those veterans age 65 and older will increase from a present total of 6.7 million to a peak of 9 million by the year 2000. Veterans 75 and older will increase from today's 1.4 million to 2.6 million in 1995, and more than triple over the next 15 years to at least 4.4 million.

With these statistics in mind, we believe that over the next 10 years VA will have to change its configuration of services to be able to provide treatment services to a larger number of older veterans.

Mr. Chairman, VA has not developed a comprehensive plan to meet the needs of an aging veteran population. Funding to support increased expansion of VA nursing care beds has been lacking, whether through new construction or conversion of existing acute care beds. Under current policy, 40% of the extended care provided veterans by VA is to be furnished in community nursing homes. An additional 30% of extended care services is provided by VA and the remaining 30% is provided by State Veterans Homes.

A review of the workload in the VA's community nursing care program from FY

1985 thru FY 1988, shows a steady increase in the numbers of patients treated, admissions, and average daily census. Available figures reflect the following:

	Average Daily Census	Admissions	Patients Treated
FY 85	11,444	28,487	38,907
FY 86	12,026	29,753	41,124
FY 87	12,251	29,986	41,925
FY 88	12,405	29,350	42,232

By contrast, in FY 1989, the cumulative workload totals were:

	Average Daily Census	Admissions	Patients Treated
FY 89	9,305	20,606	32,209

Mr. Chairman, these statistics are alarming. While VA's overall CCNH workload totals have been significantly reduced, down 24% between FY 1988 and FY 1989, there has been no corresponding increase in either the state home nursing program, or in VA nursing homes. Further, for the first four (4) months of FY 1990, the contract community nursing care workload has been reduced another 1.6% compared to the same period in FY 1989. In fact, VA's FY 1990 workload projections in the CCNH program estimate an average daily census of only 9,102 and 31,989 patients treated. Both of these figures will fall well below the previous year's levels.

Mr. Chairman, veterans' nursing home care, whether provided in a VA facility or contracted for within the community, is not a mandated service. Statutory authority for VA nursing home care was established by P.L. 88-450, and codified in section 620, title 38, United States Code. It states VA may provide these services which means, no veteran, service-connected or nonservice-connected, has entitlement to this level of care. As there is no statutory mandate, equity of access to this level of care has not been applied by VA.

Beginning in FY 1989, VA medical centers had the flexibility to use community nursing home funds for other patient services mandated by law. Given this flexibility, each VAMC reacted differently. Some medical centers diverted contract nursing funds and limited placement only to veterans with service-connected disabilities. Other VAMCs maintained the community nursing home program and served both service-connected and nonservice-connected veterans but, also, substantially reduced the length

of nursing home contracts with the community providers. In most cases these contracts were reduced from six (6) to three (3) months or less.

With continued reduced funding for the contract nursing care program in FY 1990, community nursing home funds were distributed to VAMCs based on their FY 1989 levels of service. We understand VA provided additional funds to VAMCs from the community nursing home reserve in January 1990, however, based on the VA workload statistics for the first four (4) months of this fiscal year, it appears VAMC directors have not been increasing the level of community nursing home placements.

In FY 1988, the contract nursing home care program provided approximately 38% of all veterans nursing care, while in FY 1989 this level was reduced to 31%. In FY 1990, Mr. Chairman, this level is projected to be even lower.

In our view, as long as this level of care remains discretionary there will be a reluctance among medical center directors to utilize contract nursing care funding for its intended purpose. Also, even though new VA nursing care units have been under construction and some have recently been activated, other operating units have reduced their bed levels. In effect, this manuvering has resulted in a net loss rather than an increase of VA nursing care beds. Correspondingly, only the state home nursing care program has shown a slight increase in workload over the past two fiscal years.

Mr. Chairman, The American Legion views the issue of providing for the aging veteran seriously and believes that until a comprehensive aging plan is developed by VA, certain segments of the veteran population will continue to be underserved.

Community nursing home care is a vital component of VA's overall approach to providing long-term care. Facing a rapidly aging veteran population, VA cannot continue to divert funds from the community nursing care program and still meet the long-term care needs of the veteran community. Even though CCNH funds were supposedly earmarked for FY 1990, it is our understanding that sequestration and other factors have forced VA to reduce these funds. We feel very strongly that there is a need to restore CCNH funding to at least FY 1988 levels.

Mr. Chairman, based on the current utilization rate of veterans requiring nursing care, we can only project that with an expected increase in veterans age 65 and older over the next 10 to 20 years, more demands will be made on all levels of VA supported nursing care. All three components of VA nursing care: VA owned and operated nursing home units, community nursing homes, and state veterans nursing homes must be prepared to absorb the anticipated workload. As has been the case in FY 1989 and FY

1990, the percentage of the total VA nursing care workload placed in community nursing homes has steadily decreased, without a parallel increase in VA or state home nursing care programs.

We believe many veterans today are receiving neither adequate nor fair treatment in the provision of VA long-term care services. The American Legion encourages this Subcommittee to conduct a full review of the critical issue of the provision of community nursing care services to those eligible veterans who are in need of such services.

Mr. Chairman, that concludes our statement.

TESTIMONY OF MANOR HEALTHCARE CORP./MANOR CARE, INC.

TO THE

HOUSE VETERANS SUBCOMMITTEE

ON

OVERSIGHT AND INVESTIGATIONS

MARCH 28, 1990
WEDNESDAY

Mr. Chairman and Members of the Subcommittee:

Manor Care appreciates the opportunity to present our perspective on the challenges facing you in meeting the nursing home care needs of America's veterans. We are dedicated to providing high quality service to each resident and are proud of our performance record as a contractor under the Department of Veterans Affairs community nursing home program. My name is Joseph Schmitt and I am Vice President of Operations for our Southeast Region.

I want to applaud your diligent oversight and legislative activity to carry out the commitments made to the nation's military veterans. You know the demographics of the aging veteran population and their changing needs for health care, particularly nursing home care and other long term care services. What I can offer you is a perspective from the front lines of caregiving about the potential and realities of the VA community nursing home program. In addition, it is vital to discuss some of the related, broader nursing home issues and trends confronting the nation.

Before addressing the important issues for this hearing, I would like to give you a brief overview of Manor Care.

* Our traditional focus is on providing highly skilled nursing and rehabilitative services. This service is enhanced by an increasing variety of specialized treatment units (notably 33 units for Alzheimer's patients and 6 units for patients requiring sub-acute rehabilitation).

* Our goal is for our 157 nursing homes to be the most desirable in their communities. A continuous process of construction and renovation maintains our market position.

* We have 18,000 high quality people working for our residents. We are increasing the emphasis on the training and development for both new and existing employees.

* Many of our standards and procedures, in such areas as quality assurance, staff development, and resident assessment, lead the industry. To increase the quality of nursing home care we supported the landmark Federal nursing home quality legislation now being implemented affecting each facility participating in Medicaid or Medicare.

Overview

With regard to long term care, the veteran population is recognized as the vanguard for an aging nation. The Veterans' Affairs Committees, the veteran service organizations, and the Department have done a thorough, conscientious job on planning for the increasing number of aged veterans. But there is a time to plan and a time to act. Our concern, simply stated, is that enough of the right things are not actually being done to meet nursing home care objectives.

Almost one year ago, at your hearing on "Health Care Services for Aging Veterans", the Chairman expressed the Subcommittee's interest in understanding if the "growing number of veterans waiting for nursing home care is a temporary aberration or a preview of the future." We believe, Mr. Chairman, that it is a preview of the foreseeable future.

This conclusion is based on challenges regarding nursing home care, in general, and the VA nursing home care, in particular. The underlying and worsening problems are the Federal funding restrictions and greater demand for nursing home

beds and professionals. The "age wave" is about to swamp the government's political willingness to fund and the nation's structural capacity to provide long term care. The situation is not inescapable, but it will take significant, short-term adjustment.

There are two basic needs for continual adjustments of policy and programs to reality.

The first area for adjustment is VA planning assumptions and service objectives. For example, projections of need are usually lower than actual because of ever lengthening longevity. Similarly reconsidered should be VA's objectives of serving 16 percent of those who will need nursing home care, 40 percent of whom will be cared for by community nursing homes. Although the niche targeted for service may now be larger than 16 percent, even this minimal objective could be jeopardized by the budget. Chart 1 shows the trends in number of nursing home patient days since 1980 for each of the three provider formats.

The second area is federal funding and service commitments. The immediate and major barrier to service is cutbacks in the growth of federal appropriations. We recognize the Committee's desire to increase VA nursing home funding, at least to restore funding to the 1988 service levels. If there are continued reductions in federal funding, it is important to directly link these decisions to targeting of services, as politically difficult as that may be. The needs of America's veterans will not be served by continuing or taking on more expensive commitments than can be sustained.

Community Nursing Home Program Utilization Down

Most important for this hearing is the need for continual adjustment of policy and programs regarding the community nursing home program.

The objective of 40 percent utilization of community facilities is maintained despite the evidence that this target has never been achieved and that the shortfall is increasing. Most noteworthy, the percentage has been dropping since 1985. In fiscal year 1991, the community nursing home utilization is budgeted to be 28 percent. Chart 2 shows the trend in the percentage utilization of community nursing homes.

The huge VA budget deficit of $850 million brought major changes in 1988, which have generally continued. VA allowed funds earmarked for community nursing homes to be used for other health purposes. Contracts were reduced from the typical 180 days to 45 days (San Antonio) and 90 days (all other nursing homes). Many nursing centers froze the home rate.

Like other VA contractors, we have had to reduce our amount of service under the community nursing home program. In the last 3 years, we have not renewed many of our facility contracts, dropping from 80 to 60 (and only 40 facilities are currently active participants). Our average daily VA census is about half of its high of 300 in March, 1987.

To meet VA's target for community nursing home utilization, the average daily census will have to increase by 104 percent by the year 2000 and 173 percent by 2010. Recent experience compels that two questions be asked: (1) What will VA change to accomplish such a turnaround, especially considering pressures to cut reimbursement rates? (2) How will VA adjust its other programs if the percentage continues its declining trend?

For the community nursing home program to meet the 40 percent service objective, three specific issues must be addressed: the period of coverage, reimbursement rates, and the

"infrastructure" needs for nursing home care.

Variability in Periods of Coverage for Nonservice-Connected Care

As you know, care for nonservice-connected health needs is legislatively authorized for up to six months in community nursing homes. The VA structure leaves to each VA medical center responsibility to allocate its health funding, among types of care (e.g., hospital and nursing home) and service provider (e.g., community nursing homes and state homes). Furthermore, because nursing home care for nonservice-connected reasons is discretionary, rather than a veteran's entitlement, the length of coverage is a direct function of the amount of money appropriated.

One result of this arrangement is wide geographic variations in coverage and variations within medical center areas. There is not an explicit nationwide benefit. The other result is that VA coverage has become a shorter, transitional benefit until Medicaid eligibility is established. In some localities, the benefit has largely disappeared.

Unfortunately, few veterans understand and are satisfied by this arrangement. Their expectations about nursing home coverage from the VA are analogous to their thinking Medicare will automatically cover their needs. Yes, the Medicare nursing home benefit is up to 100 days, but the reality is that this benefit is so conditioned by insurance-like fine print that it covers only three percent of total patient days. Our nursing home administrators are on the front line feeling the wrath from veteran patients who find out how little VA covers.

Adequacy of Reimbursement for Community Nursing Home Care

Since the total supply of community home beds is far greater than the demand from the VA for meeting its 40 percent utilization target, why is the utilization trend declining? Clearly, it is the result of VA efforts to arbitrarily control reimbursement below levels adequate to provide quality care and attract a sufficient share of scarce beds.

The costs for care are rising significantly. Major reasons for community nursing home cost increases are (1) rising labor costs, particularly to compete for nursing staff, and (2) upgrading the quality of care to implement the 1987 Federal nursing home reform legislation, which affects facilities participating in Medicare or Medicaid. The reforms, such as nurse aide training and resident assessment will compel unprecedented improvements in care.

In addition, the overall supply of beds is not growing as fast as the population is in need of care. One consequence is a natural triaging of patients, resulting in a greater intensity of services and the average cost of care.

It is difficult for us to make direct per day cost comparisons, especially for comparable patients, between our cost accounting system and VA reimbursement. For the immediate purposes of this hearing, we have tried to develop the best approximation. Currently, our average cost for direct patient care varies across our regions from $68 to $90. Our current VA contract rates range from $57 (Fort Worth) to $93 (D.C. and Chicago) for skilled care. For intermediate care, the range is from $42 (Fort Worth) to $86 (D.C. and Chicago). Generally, VA payment rates have increased 3 percent a year for the last 3 years, while our average company costs have increased 6 percent.

In contrast to private paying patients, VA reimbursement is about 10-12 percent less for comparable patients. Our average Medicare payment rate is $117 (includes ancillary services, like

drugs and medical supplies) and our average Medicaid rate is $55 (does not include ancillaries). Medicaid per diem in our states ranges from $40 (Texas) to $75 (Florida).

Presently, VA's general approach to contracting with community nursing homes is to hold reimbursement to the Medicaid rate plus 10-15 percent. For many reasons, the Medicaid rate is totally inappropriate as the basis for VA services. Many states underfund Medicaid services, relying implicitly on a subsidy from private paying patients to compensate. Often, the rates are more a function of state budgets than nursing home costs. In terms of methodology, the VA rate is a facility-specific, predetermined all-inclusive rate. Medicaid reimbursement methods, on the other hand, vary greatly from state to state and tend to be cost-minus formulas. Some Medicaid plans pay according to patient needs; others provide incentives for heavy-care patients. Because Medicaid is the largest single purchaser of nursing home care, its rate-setting leverage is extraordinary. VA and Medicaid patient characteristics also differ. VA patients, typically, have short term lengths of stay, requiring greater up front care at higher cost.

The ability of nursing homes to deliver high quality services to a more dependent veteran population depends in part on the Federal government's willingness to support quality through reimbursement rates.

Attracting Community Nursing Home Participation

The shortage of nursing home beds in most areas of the nation causes admissions difficulties for many patients, especially for those seeking higher quality care. High facility occupancy levels and waiting lists for the best facilities are indicators of the increasing competition for nursing home beds.

Mindful of the budgetary constraints, we recommend your consideration to the following three approaches which would improve the community nursing home programs effectiveness and attractiveness.

One, eliminate the all-inclusive rate which is based on the Medicaid system. Reimbursement guidelines should be set in some relation to Medicare reimbursement rates and methodology. For example, VA could adopt a rate calculation formula that is similar to the Medicare prospective payment option for nursing homes to cover routine costs of operating services (e.g., nursing, dietary, laundry, housekeeping). Special services would be paid on a normal fee for service basis. Such a methodology would be advantageous because it would account for variations in regional and local market conditions.

Two, incorporate specific incentives into the VA reimbursement methodology for desired outcomes. For example, reimbursement for those patients requiring special kinds of service, such as tube feeding or sub-acute rehabilitation, could be segregated out of the all-inclusive rate, and paid under a separate classification system. Such incentives would be particularly useful in helping to place heavier care patients. It is our understanding that a few state Medicaid programs already offer enhanced rates for special levels of care.

Three, identify a basic package of services, upon which individuals are permitted and encouraged to build. This approach would recognize and accommodate the diversity among people's needs, wants, and preferences, and the flexibility for change.

Every resident is entitled to high quality nursing care and related services. However, nursing home care is more than a service; it is a way of living. Veterans and their families should have the widest possible range of choice in their living

and care arrangements.

In particular, many people want a level of service and accommodations higher than the government is able to fund. Present Medicare and Medicaid law, while requiring that residents receive the basic covered services according to professional standards, allows for the purchase of uncovered services and items.

Infrastructure Needs

Before closing, I would like to take this opportunity to address increasingly serious infrastructure needs for nursing home care.

The Pepper Commission's November 8 statement of findings cited, "The number of elders requiring institutional care will more than triple by 2030 from 1.8 million in 1990 to 5.3 million in 2030."

Implicit in these findings is that, somehow, if a person needs care, there will be a bed available. But the public policy problem buried in these numbers is that the growth in demand will increase about twice as fast as the recent construction trend.

Trend data about the supply side of nursing home care was recently reported by analysts from the University of California, San Francisco in the Health Care Financing Review. For the period of 1978-1986 they found "expansion in numbr of beds had not kept up with increases in the aged population," with the number of beds decreasing from 54.7 to 52.1 per 1000 elderly.

Chart 3 shows the annual percentage growth rates and declining trend line for beds during this period.

Chart 4 addresses the short-term implications of the nursing home bed demand and supply trends, with the following compelling disparities:

* To meet the bed demand, a net increase of over 964,000 beds is needed in the '90s;

* In 1993, the total number of people requiring nursing home care will exceed projected bed supply;

* In 2000, demand will exceed supply by over 20 percent, with a shortfall of over 538,000 beds.

Projections by the VA indicate that the number of veterans requiring long term care by the year 2000 will top 290,000. VA expects to provide care to 16 percent, or 46,000 patients, but what about the remaining 144,000 veterans? Where will these persons find adequate institutional care in the wake of severe bed shortages.

The long term care industry needs capital investment of almost $34 billion (without adjusting for inflation) for new facility construction by the year 2000, or about $35,000 per bed. This price tag does not include the large capital requirements for renovating or replacing old facilities.

Direct government capital investment is impossible given the present deficits, and indirect government support through Medicaid and Medicare simply will not be sufficient. The optimal role for the government would be to focus its policies on attracting private capital into nursing home investment.

Conclusion

We appreciate the opportunity to testify before you today. This occasion represents the first time Manor Care has offered public comment about long term care for veterans.

Mr. Chairman, we hope your subcommittee closely examines the long range implications of a rising veteran population and the VA's capacity to meet their growing health care needs. We encourage the adoption of uniform, nationwide application of long term care benefits to ensure a system of fairness and equity among all veterans. We also suggest that modifications be made in the current reimbursement structure to foster greater participation by the private sector in the community nursing home program. We believe this program currently is vastly underutilized. The community nursing home program affords veterans health care close to their families and friends, which helps tremendously in meeting their individual psycho/social needs.

We would like to work closely with your committee and the VA in the future to encourage increased participation by long term care providers in offering quality health care to all veterans.

Chart 1 - Average Daily Census for 3 Nursing Home Programs

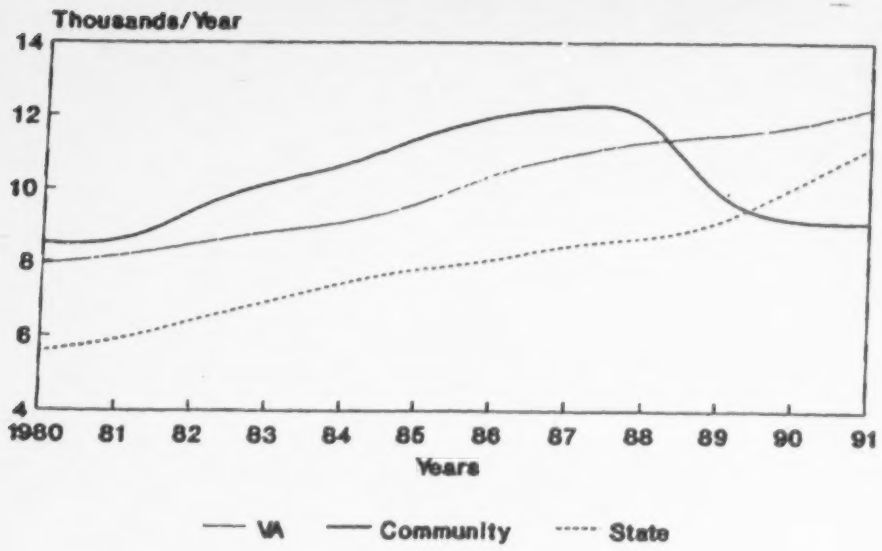


Chart 2 - Percentage Use of Community Nursing Homes

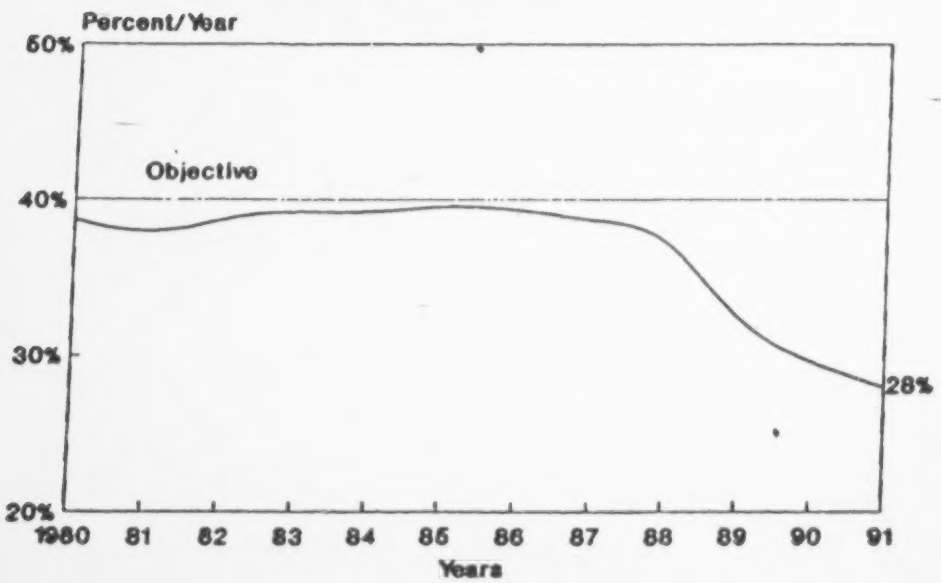


Chart 3 - Trend in Nursing Home Bed Supply Growth

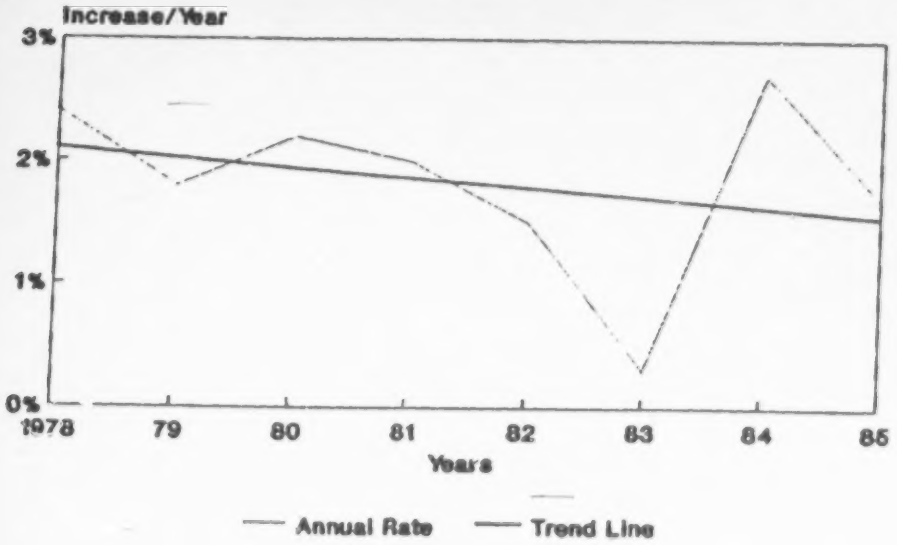
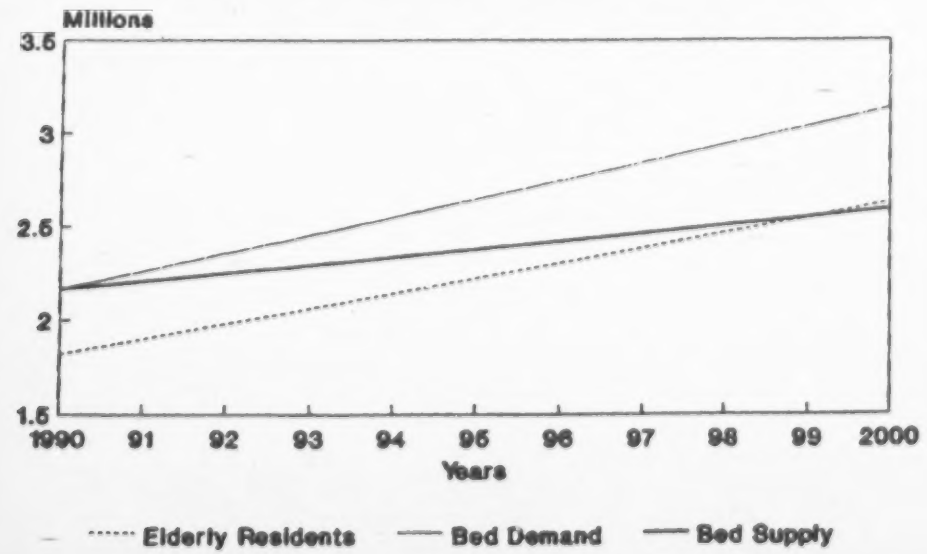


Chart 4 - Nursing Home Beds: Projected Demand and Supply



WRITTEN COMMITTEE QUESTIONS AND THEIR RESPONSE

MANOR
HEALTHCARE CORP

May 4, 1990

The Honorable Lane Evans
Chairman, Subcommittee on
Oversight and Investigations
Committee on Veterans' Affairs
335 Cannon House Office Building
Washington, DC 20515

Dear Chairman Evans:

Thank you for your follow-up correspondence regarding our testimony before the Subcommittee on Oversight and Investigation. We appreciate the opportunity to provide you with additional information, and hope our response to your questions will be useful.

1. How many Manor Care nursing homes accept Medicaid? What percent of Manor Care patients are Medicaid?

Approximately 95 percent of our nursing facilities accept Medicaid patients. The distribution of residents in an average center is the following:

Private Pay -- 51 percent
Medicaid -- 31 percent
Medicare -- 14 percent
Other (Insurance, HMO) -- 3 percent
VA -- 1 percent

2. How many Manor Care nursing homes are not participating in the VA community nursing home program? Of these facilities, how many were contacted by the VA last year and encouraged to participate?

Presently, 60 Manor Care facilities participate in the VA community nursing home program, out of a total 160 nursing homes. Of the 60 facilities, only 40 percent currently have VA patients. The number of non-VA facilities that have been contacted by local VA medical centers is unavailable.

3. What is the average length of stay for all Manor Care nursing care patients? For Manor Care Medicaid patients?

The average length of stay for all Manor Care patients is about 200 days, while the average length of stay for Medicaid patients is one to two years.

10770 COLUMBIA PIKE SILVER SPRING MARYLAND 20901 (301)593-9630

4. How many Manor Care facilities in the VA program which accept Medicaid provide care to veterans at the Medicaid rate? At Medicaid + 15%? At more than Medicaid + 15%?

No Manor Care home provides VA care at the Medicaid rate, although a few facilities do offer care at rates a few dollars above Medicaid level. Fifteen of the 40 homes admitting VA patients strictly apply the Medicaid plus 15 percent rate. The remaining homes are able to support higher negotiated rates. The adequacy of the individual state Medicaid rate greatly determines how we contract with the local VA medical center, or if we enter into contracts at all.

5. How many Manor Care nursing homes have been asked by a VA medical center to provide pricing data or document higher costs?

In all cases, we are asked to submit pricing data to the local VA medical center before negotiating new contract rates. In many cases a baseline contract rate is established with percentage increases in subsequent years.

6. How many different daily rates are paid for nursing home care provided by Manor Care? What is the range of the per diem cost?

The number of rates in a facility differs based on the level of care, type of room, and diverse amenities. We estimate about a dozen different daily rates in the average home. The range of per diem cost in a given home varies from $55 per diem for an ICF Medicaid patient to $300 per diem for a spinal cord injury patient receiving extensive skilled care and therapy.

7. What percent of the cost of care provided by Manor Care to Medicaid patients is provided by an "implicit subsidy?"

Our average Medicaid costs are $65 per day, while our average Medicaid rate is $56 per day. Consequently, the "subsidy" from other payor sources is $9 per day (16 percent). Again, the subsidy can vary based on the adequacy of the state Medicaid rate.

8. According to your testimony, per diem rates which are higher than Medicaid provide an "implicit subsidy" for Medicaid patients. If the VA per diem rate for community nursing home care was increased in relation to Medicaid, why would the higher VA per diem rate not provide a subsidy for Medicaid patients? Why should the VA provide a subsidy for Medicaid?

Our company average VA contract rate (skilled and intermediate care) is about $75 per day, which is below our average VA costs of $77 per day. Since most of our VA patients are intermediate care and located at facilities with lower rates, the actual VA rate received is $56 per day. Thus, VA patients do not subsidize Medicaid patients. On the contrary, private pay patients provide a subsidy for both Medicaid and VA residents.

9. What is Manor Care's performance and quality record? During 1988, how many Manor Care nursing homes were judged to have a deficiency by a government regulatory agency? In 1989?

As you know, each facility is surveyed annually by the state to assure quality compliance. The results of each survey are a matter of public information. You may be interested to know a state survey reviews 16 different categories pertaining to the operation of the facility and the delivery of patient care. Within each category there is virtually an unending number of factors the surveyor can critique. The citing of a deficiency does not necessarily indicate that a facility is providing substandard care. For example, a dietary deficiency might indicate that a pat of butter was warm, or it could mean that a low sodium diet was not observed. Also, deficiency citings do not reveal the frequency of the problem. Are butter pats continually served warm, or was the warm butter pat a one-time occurrence?

In 1988, the Health Care Financing Administration released a national consumer guide to nursing homes, evaluating each facility according to 32 performance indicators. Over half of the Manor Care facilities surveyed had two deficiencies or less. It is our understanding this number is significantly below the national average. Manor Care has its own internal Quality Assurance Department to ensure that our patients receive the best level of care possible. Our comprehensive quality assurance tool is considered foremost in the industry.

10. Please describe the "greater upfront care" referred to in paragraph 3, on page 5 of your written statement and explain the associated higher cost you reported.

New admissions typically undergo extensive observation and evaluation by the nursing staff in the first three months of care, particularly if the patient has been recently discharged from a hospital. Also, a patient during this time period is more likely to receive ancillary services, such as physical, speech, and occupational therapies. Because a higher level of staff time is utilized, the costs are likewise higher.

11. How many Manor Care nursing homes have a waiting list? How many person are on the average waiting list and what is the average amount of waiting time for admission?

Waiting list statistics are maintained at the facility level, and vary by the type of care provided, such as skilled, intermediate, Alzheimer, etc.

12. What is the range and average Medicaid payment received by Manor Care for skilled care when ancillary services are included? For intermediate care when ancillary services are included?

The average Medicaid skilled rate with ancillaries ranges from $60 (Texas) to $75 (Florida) per day. For ICF patients, the range is from $40 to $50 per day.

13. What is the average Manor Care private pay per diem?

The average private pay rate is $86 per day.

14. According to your statement, VA reimbursement is about 10% to 12% less than private pay for comparable patients. How does VA reimbursement compare to Medicaid for comparable patients?

Actual VA reimbursement in our homes averages slightly more than the Medicaid rate. Since the VA rate is all inclusive and most Medicaid rates are not, the cost associated with treating a VA patient may be greater than the cost of providing care to a Medicaid patient. Furthermore, VA patients tend to be sicker than many other Medicaid patients, thereby increasing the cost of their care.

15. According to your testimony, the Medicaid rate is a cost formula, but it does not recognize all the costs associated with the treatment of your patient population. What costs are not recognized and what percent of the total cost of care do these unrecognized costs represent?

Medicaid reimbursement systems vary dramatically. Some states pay prospectively; other reimburse retrospectively. Some states use the facility's historic cost as a basis; others simply adopt a flat rate. Because most states are unable to adequately fund their Medicaid programs, they use devices such as ceilings or caps on the various cost centers (General Administration, Operating, Nursing, Capital) in order to limit the expense. Unfortunately, these caps are arbitrary and usually do not reflect the actual costs of operation.

Again, we hope these answers are beneficial to you, and invite you to contact us should you have additional questions.

Sincerely,

Joe Schmitt

Joe Schmitt
Vice President, Public Affairs

Questions Submitted By Congressman Lane Evans

To Mr. Ernest L. Harper
Assistant Deputy Assistant Secretary for Aquisitions
Department of Veterans Affairs

Hearing On DVA Community Nursing Home Care Program
(March 28, 1990)

1. Liaison with the nursing home rate setting body in each state is characterized as "essential" in VA Circular 005-90-1 (dated January 5, 1990). Please provide:

a. The number of states in which liaison with the rate setting body has been established; and

b. The deadline or target date for establishing this liaison in all states.

A. The Department has not collected information on implementation of the liaison function within each state. Office of Acquisition and Materiel Management staff is monitoring implementation and has discussed the requirements with acquisition officials at many medical centers. We will continue our oversight to help ensure full compliance with the circular.

2. According to this circular, the liaison will be responsible for disseminating information to the medical center contracting offices within the state.

a. In how many states has information been disseminated to contracting officers by the state liaison?

b. What is the deadline or target date for this dissemination? How frequently will information be provided by the liaison to the medical centers?

A. The Department has not collected information on dissemination of information from state nursing home rate setting bodies on a state by state basis. As indicated in the response to the above question, we will continue our oversight activities to ensure compliance. The frequency of dissemination will be determined by the degree of activity of the rate setting body in each state.

3. What followup is planned for this circular and what is the followup schedule?

A. The Department will publish followup guidance for this circular and the Community Nursing Home Program as required. This guidance is conveyed through subsequent circulars, TWX, monthly national conference calls, and other media. In addition, staff in the Office of Acquisition and Materiel Management frequently discusses program requirements with medical center acquisition officials.

CONGRESSMAN EVANS

Question: 1a. Is the VA paying more than necessary for the community nursing home care it is purchasing?

Answer: While it has been suggested, there is no conclusive evidence to suggest that VA is paying more than is necessary for Community Nursing Home (CNH) care. We anticipate that our review of the CNH rate structure may provide such an indicator.

Question: 1b. How much can the cost of care now being provided in the community nursing home program be reduced without decreasing the quality of care provided? The amount of care provided?

Answer: There is no data available to indicate how much (or if) the cost of care could be reduced without decreasing the quality of care or the amount of care provided.

Question: 2. Is it more costly for community nursing homes to provide care to veteran patients than non-veteran patients? What additional costs of caring for veterans has been completely documented?

Answer: There is no information to suggest that the cost of care for a veteran in a nursing home is more (or less) than the cost of care for a non-veteran.

Question: 3a. How many times have competitive bids been used to obtain community nursing home care?

Answer: Competitive bids have never been used in the CNH Program.

Question: 3b. How many VA community nursing home contracts are sole source contracts?

Answer: All CNH contracts are sole source contracts.

Question: 4a. How many community nursing homes do not participate in the department's program?

Answer: Approximately 14,500 nursing homes do not participate in the CNH Program.

Question: 4b. How many non-participating community nursing homes were contacted by the VA last year and encouraged to participate? What was the result?

Answer: The Department does not collect information on the number of non-participating nursing homes which were encouraged to participate. However, the number of homes with VA contracts has increased from 3,200 to more than 3,400 over the past few years.

Question: 4c. How can the number of nursing homes participating be increased?

Answer: VA could actively recruit more homes into the CNH Program. The most effective recruitment mechanism would probably be the price VA would be willing to pay for care.

Question: 4d. What specifically has the VA done to increase participation?

Answer: Based on a 1986 recommendation by the Office of Inspector General (OIG), departmental policy now states that VA medical centers "conduct, as needed, surveys of the nursing home market, to ensure that the supply of nursing homes under contract is adequate to meet the needs of patients".

Question: 5. Medical centers are directed to use the community nursing home's Medicaid rate as a basis for negotiations and add as much as 15% to cover the all-inclusive nature of VA's contract.

How many medical centers follow this directive?

Answer: The Department has not collected this information. However, in a review of the 10 IG audits conducted after the Department's policy change, in 1988, to a "Medicaid plus 15 percent" policy for CNH rates there have been the following audit findings:

Six VA medical centers (VAMCs) used the Medicaid rates as a basis for negotiations, but did not maintain sufficient documentation for rates above the "Medicaid plus 15 percent" level in the contract files.

Two VAMCs used the Medicaid rates as a basis for negotiations and had minor compliance problems.

Two VAMCs did not obtain or use Medicaid rates as a basis for negotiating rates.

Question: 6a. How many VA contracts with community nursing homes have a per diem rate which is:

a. Less than the Medicaid rate;
b. Equal to the Medicaid rate;
c. Equal to the Medicaid rate plus 1% to 5%;
d. Equal to the Medicaid rate plus 6% to 10%;
e. Equal to the Medicaid rate plus 11% to 15%;
f. Equal to the Medicaid rate plus more than 15%.

Answer: The Veterans Health Services and Research Administration does not collect this information because of its limited usefulness. Medicaid rates often change during the year and also change once the year has ended, ie. retroactive payments. This factor greatly limits the value of a point-in-time review of rates. In 1989 the Office of Inspector General (OIG) conducted a survey of VA facilities on CNH skilled contract rates in relationship to the current skilled Medicaid rates. The OIG findings are listed below:

a.	Less than the Medicaid rate	151
b.	Equal to the Medicaid rate	5
c.	Equal to the Medicaid rate plus 1% to 5%	113
d.	Equal to the Medicaid rate plus 6% to 10%	141
e.	Equal to the Medicaid rate plus 11% to 15%	247
f.	Equal to the Medicaid rate plus more than 15%	2,267

Question: 6b. What percent of community nursing homes being paid a per diem rate exceeding Medicaid by more than 15% have provided complete documentation justifying the higher rate?

Answer: The Department does not collect this information. The findings of the most recent IG audits indicate that the documentation in the contract files needs to be improved.

Question: 7. A 1986 OIG audit on the community nursing home program reported the VA could save about $61.3 million annually by paying the Medicaid rate plus actual costs of extra supplies and services furnished to veterans. Based on this estimate, how much more community nursing home care could be provided to veterans if existing program resources were used more effectively?

Answer: The Department did not concur with the OIG's findings on cost savings. The report assumed that nursing homes would contract for the Medicaid price plus the cost of additional services and supplies. The Department had no evidence that nursing homes would find this price acceptable. In addition, the cost savings were based on a sample of eight VA facilities which was too small to draw nationwide conclusions. However, if another $61.3 million were available for the CNH Program in 1986, 2,600 more veterans would have been in the program on any given day.

Question: 8. The Medicaid rate is not all-inclusive and the cost of additional services under Medicaid are itemized. When the VA negotiates an all-inclusive contract, how many medical centers use the itemized cost for additional Medicaid services as the basis for negotiating an all-inclusive contract?

Answer: The Department does not collect this information.

Question: 9a. Is it realistic for medical centers to obtain care for veterans from community nursing homes at the established Medicaid rate? At 115% of the Medicaid rate?

Answer: It is possible for VA medical centers to contract with nursing homes at the Medicaid rate or at 115 percent of the Medicaid rate. However, if nursing homes do not find the rate attractive, they will assign VA-referred patients a low priority for admission. This action would create unnecessary hospital days at VA medical centers.

Question: 9b. What other basis should be used for obtaining community nursing home care? Why?

Answer: VA is exploring a number of models, including Medicare, to determine the appropriateness of the policy on rate setting in the CNH Program.

Question: 10a. If rates for community nursing home care were negotiated by medical centers as required by current VA guidelines, how many fewer community nursing home beds would be available to the VA?

Answer: The Department does not have a reliable indicator to make such an estimate. In reviewing the findings of the most recent OIG audits, which show a higher degree of compliance with VA policy, there does not appear to be a significant change in bed availability.

Question: 10b. Please list the incentives and disincentives, if any, for negotiating contracts with community nursing homes as required by current guidelines.

Answer: From VA's perspective, the main incentive (or advantage) of using the current system for CNH rate negotiation is its ease of administration. Medicaid rates are readily available. Additional justification for higher rates must be provided by the nursing homes. The major disincentives (or disadvantages) of using the current system is that Medicaid rates can change during the year and/or States can change the rate retroactively. VA contracts are generally one year in duration and payments may be out-of-line with policy depending on the time of year.

The Department is examining its policy on rate negotiations to determine its adequacy and implement any necessary changes.

Question: 11. How is the VA's maximum per diem rate for community nursing homes determined by the Department and what does this maximum represent? How is this rate related to Medicaid rates?

Answer: Each year the Department establishes a maximum per diem rate. This practice began in the mid-1970s following a review of Medicaid rates. The maximum rate was established as a cost containment measure so that rates would not approach the statutory maximum of 45 percent of the cost of care in VA medical centers or 50 percent in special circumstances. (The statutory maximum is used for high cost areas and for patients with special care needs. These rates are approved in Central Office). The maximum per diem rate is adjusted each year for inflation based on a review of the inflation rate for the Medicaid Program, private pay and VA's own experience.

The CNH rate is not related to Medicaid rates except as a historical benchmark and as one indicator of inflation.

Question: 12. Where are Medicaid rates not a reliable indicator of the current market value of nursing home care in the local community?

Answer: As part of VA's review of the CNH Program's rate structure, we are examining this issue closely. The Committee has requested and will be receiving quarterly progress reports on this subject.

Question: 13a. How many nursing homes have been requested to provide actual cost data? Their annual financial statement?

Answer: The Department does not collect this information.

Question: 13b. What percent of community nursing home contract rates are properly justified?

Answer: The Department does not collect this information at this time. The findings of the most recent OIG reports indicate a significant improvement in documenting rate negotiations.

Question: 14. What lessons has the Department learned from Inspector General audit findings on the VA community nursing home program? How have those lessons been used? How will those lessons be used?

Answer: In 1986, the Department learned that its policy on CNH rate negotiations needed to be strengthened. The policy was strengthened and the "Medicaid plus 15 percent" policy was established. Currently, the Department is concerned that this policy is inadequate and the policy is being evaluated. Necessary changes will be made following this review.

Question: 15. According to Dr. Winship's testimony, the Department has responded to the IG findings with manual changes, instructions, workshops and by other means.

What are the results of those responses by the Department?

Answer: In reviewing the 10 audits which were conducted after the new policy was in place for a year, the OIG's findings show marked improvement over the previous findings when Medicaid rates were not being used as a basis for CNH rate negotiation. The Department has responded to the audit findings and is contacting State officials and using Medicaid rates as a basis for negotiations. While there is still room for improvement, especially in the area of documentation, VAMCs have moved in the right direction in CNH rate negotiations. (See Question #5).

Question: 16. Specifically, how and when is the Department going to follow-through to make certain rate setting decisions are better documented?

Answer: Currently, the Department is evaluating its rate setting policy to determine if it is appropriate. Assuming there will be some policy change, the Department will publish those changes and begin to require VA medical centers to certify that the rates established conform to the policy. This process should be completed by June 1991. We will report our findings in a future progress report on this subject.

Question: 17. According to Dr. Winship's prepared statement, the community nursing home per diem rate is 44% less than the VA nursing home per diem rate. Please detail the differences in cost between these two rates.

Answer: The Department has found that nursing homes, whether VA-operated or operated by community hospitals, are more expensive than free-standing community facilities by virtue of the hospital affiliation. In VA-operated nursing homes, a wider array of services are available. A 1987 evaluation of VA's nursing home programs, conducted by Price Waterhouse, found a greater emphasis on expensive rehabilitation services in VA nursing homes than in community facilities. VA nursing homes use a significantly higher proportion of registered nurses and licensed practical nurses (as opposed to nursing assistants) than community nursing homes. As a function of the hospital affiliation, administrative, engineering and building management costs are higher. These factors explain the difference in per diem rates.

Question: 18a. How and why was the current VA provider mix for nursing home care established?

Answer: The President's FY 1987 budget announced a new program mix for VA's nursing home care programs. Thirty percent of the care would be delivered in VA-operated beds; 40 percent would be provided through community nursing homes and 30 percent through the State Home Program. (The previously planned program mix was: 40 percent - VA-operated; 40 percent - CNH Program; 20 percent - State Home Program). The mix was adjusted to reflect the interest among States in the State Home Program and to reduce the number of beds VA would need to construct.

Question: 18b. What are the advantages and disadvantages of this provider mix? How should the current mix be changed?

Answer: VA views the planned program mix for nursing home care as a national goal and not a rule rigidly applied at the local level. The Department finds this flexibility to be an advantage. The program mix also appears to be reasonable. The disadvantage of this plan (or of any other planned program mix) is the lack of control VA has in implementing the plan. VA cannot control or influence the supply of beds in the community. VA also cannot direct a state to become involved in the State Home Program. At this time there appears to be no reason to change the planned nursing home care program mix.

Question: 19. Last April, during a hearing I conducted on health care services for aging veterans, it was strongly recommended that the VA develop a national plan for providing extended care.

What is the status of this plan?

Answer: A national plan has been developed and is currently under review. When approved the plan will be forwarded to the appropriate committes of Congress.

Question: 20. GAO has critized the VA for establishing a national provider mix for nursing home care which does not reflect local needs and resources. Does the provider mix now reflect local need and resources?

Answer: VA has made numerous changes to its planning guidance for nursing home care since the GAO report in 1986. We believe the guidance is much more sensitive to local needs and resources than in previous years.

CONGRESSMAN JAMES

Question: 1. What is the average cost of a 6-month nursing home care contract?

Answer: This year, the average cost of a 6-month placement in the Community Nursing Home Program (CNH) is estimated at $14,033. The average length of stay under contract is actually less than 180 days. It is 145 days. The average cost per episode is $11,304.

Question: 2. What is the breakdown of admissions of Category A, B and C's to nursing homes?

Answer: The breakdown by eligibility category is: 97.4 percent - "A"; 1.6 percent - "B"; and 1.0 percent - "C".

Question: 3. On Page 2 of your statement, you state that placements for nonservice connected conditions may be extended for 45 days under certain circumstances. What are these circumstances, and how often are the extensions granted?

Answer: Extensions can be granted in these cases under three circumstances when the need for nursing home care continues to exist. First, if the post-placement plan indicates Medicaid, and there is an unforesen eligibility problem which can reasonably be expected to be resolved during the extension period, an extension can be granted by the VAMC Director. Second, if the post-placement plan indicates private pay, and there are unforeseen difficulties, such as a temporary obstacle in the liquidation of property which can reasonably be expected to be resolved during the extension period, an extension can be granted. Third, if the patient is terminally ill and life expectancy has been medically determined to be less than 6 months, an extension can be granted. In the case of the terminally ill, the 45 day extension limitation does not apply.

In FY 1989, less than two percent of the veterans placed for nonservice-connected conditions received an extension.

Question: 4. Your testimony states that community nursing homes are experiencing occupancy rates exceeding in some instances 95%, yet the Department expects to increase its reliance on community nursing home care for veterans. The current occupancy rate suggests that there is little or no room to absorb this increased veteran caseload. Can you comment on this?

Answer: The Department recognizes the many challenges in planning for long-term care services for an increasingly elderly population. For planning purposes, the Department has made the assumption that the nursing home market will grow to meet the new demand or that other modalities of care, such as home care, will be further expanded or that new modalities of care will be developed to meet the care needs of the population.

Question: 5. What is the VA's role in finding other alternatives for care for those veterans whose contract has expired but are still in need of nursing home care?

Answer: Approximately 63 percent of all CNH patients remain in the nursing home after VA placement period. Before the placement period ends, VA staff works with the patient and family, as well as the nursing home staff, to ensure that there are adequate post-contract plans. VA staff maintains informal contact with these veterans after the contract period while providing follow-up services to other VA contract patients. The nursing home staff will alert the VA staff to issues, ranging from scheduling an outpatient visit at a specialty clinic to Compensation & Pension benefits, and we will provide assistance. Of course, if the veteran requires hospitalization, the veteran remains eligible for that care at the VAMC.

RESPONSES TO QUESTIONS SUBMITTED BY CONGRESSMAN LANE EVANS

TO RENALD P. MORANI

ACTING INSPECTOR GENERAL

DEPARTMENT OF VETERANS AFFAIRS

1. **Question:** On the final page of his prepared testimony, Dr. Winship states the community nursing home program is well managed both locally and nationally. Do you agree or disagree with this statement? Please explain your response.

Response: The Office of Inspector General (OIG) does not fully agree with the statement. Program improvements are needed from a policy standpoint as well as at the implementation level. We believe that improved controls over contract negotiation procedures are required to ensure that VA pays a fair and reasonable price for community nursing home care for veterans. We found in 24 facility audits that VA medical center contracting officers did not always comply with policy on the negotiation and rate-determination process. On a national level, we also found that VA policy no longer provides sufficient direction on contract pricing and negotiations in States with more than two Medicaid rates (such as Minnesota and Texas).

We believe that contracting officers make concerted efforts to pay reasonable prices for nursing home care. However, they often compromise that effort because they do not validate nursing home cost data when administrators request rates higher than suggested by VA policy. Also, some contracting officers are not familiar with Medicaid cost reports or rate-setting procedures. Therefore, they cannot effectively review and validate cost data provided by nursing home administrators.

In conclusion, we do not believe that the community nursing home program is as effectively and efficiently managed as it could be.

Question: Are administrative controls and oversight of the community nursing home program including medical center contracting adequate? What changes or improvements are needed?

Response: Improvements are needed in administratively controlling and overseeing the contracting process, particularly in the oversight of contract rates. Medical centers submit data on community nursing homes such as names, locations, contract rates, and applicable Medicaid rates to a database file in the VA Data Processing Center in Austin, Texas. However, we found that the file was not complete, accurate, or up-to-date.

We validated the nursing home file by (i) obtaining data on all contracts with nursing homes that were in effect as of June 30, 1989, from all 163 VA facilities that have authority to issue nursing home contracts and (ii) comparing this data to the file. The file did not include about 500 community nursing homes under contract with VA facilities as of June 30, 1989. In addition, program officials did not use the file to compare contract rates with Medicaid rates. This would have informed VA officials of the need for follow-up with contracting officers concerning high contract rates. Consequently, we believe that internal controls and oversight over the Community Nursing Home Program could be improved.

2. **Question:** Is the VA paying more than necessary for the community nursing home care it is purchasing?

Response: Our audit results indicate that contract prices exceeded costs to treat veterans by about $9 a day as of June 1989.

We determined the daily excess cost by first adjusting nursing homes' reported costs to June 1989 dollars, using McGraw-Hill Data Resources, Incorporated's Health Care Costs statistical data. We allowed a 5-percent profit margin before determining the estimated excess cost per day. The overall profit margin for the nursing homes we visited during our audit was about 1.3 percent. Since we were not able to obtain a generally accepted industry standard, we decided to use a 5-percent profit margin before determining excess costs. The $9 excess cost per day represents about 11.5 percent of Fiscal Year (FY) 1990 daily national contract rates.

Question: By how much can the cost of care now being provided by the community nursing home program be reduced without decreasing the quality of care provided? The amount of care provided?

Response: Experience has shown that unless VA management makes concerted efforts to reduce the daily contract cost of care, costs will increase. With current contract procedures, any reductions in the community nursing home budget are likely to result in reduced amounts of care provided, instead of reduced daily contract rates. We believe that through improved contracting procedures the cost of care now being provided can be reduced by at least $30 million without decreasing the quality or amount of care provided. We have no reason to believe that VA would allow the quality of care to decrease because of budget reductions. Further audit effort is planned to evaluate quality assurance controls over the nursing home care program.

3. **Question:** A 1986 OIG audit on the community nursing home program reported the VA could save about $61.3 million annually by paying the Medicaid rate plus actual costs of extra supplies and services furnished to veterans. Based on this estimate, how much more community nursing home care could be provided to veterans if existing program resources were used more effectively?

Response: If the 1986 estimate of $61.3 million annual savings were still possible, based on an average contract cost of care of about $78 in FY 1990, an additional 786,000 days of care ($61,300,000 divided by $78 a day = 785,897 days) could be provided. Using our current estimated savings of about $30 million during 1989, an estimated 385,000 additional days of care would be possible ($30 million divided by $78 a day equals 384,615 days).

4. **Question:** Medical centers are directed to use the community nursing home's Medicaid rate as a basis for negotiations and add as much as 15 percent more to cover the all-inclusive nature of VA's contract.

How many medical centers follow this directive?

Response: Contracts for nursing home care have been awarded by 163 VA medical centers. Of the 3,893 contracts in effect as of June 30, 1989, 2,267 contracts were awarded with skilled rates exceeding benchmark levels. At a given facility, some contracts met the requirement whereas others did not; therefore, the exact number of medical centers not complying with the directive could not be determined. VA policy permits contract rates to exceed benchmark levels if contracting officers obtain cost data from nursing homes which justifies higher rates. However, our current audit results caused us to conclude that contracting officers are generally not complying with VA policy on negotiating reasonable contract rates.

Question: How many VA contracts with community nursing homes have a per diem rate which is:

a. Less than the Medicaid rate;
b. Equal to the Medicaid rate;
c. Equal to Medicaid rate plus 1% to 5%;
d. Equal to Medicaid rate plus 6% to 10%;

e. Equal to Medicaid rate plus 11% to 15%;
f. Equal to Medicaid plus more than 15%?

Response: According to responses we received from 163 VA facilities that awarded contracts for nursing home care, VA had 3,893 contracts with community nursing home facilities as of June 30, 1989. Of those 3,893 contracts, 2,924 had contract rates for skilled nursing care as shown in the following table.

ANALYSIS OF SKILLED NURSING HOME CONTRACT RATES

	Skilled Contracts
a. Less than the Medicaid rate:	151
b. Equal to the Medicaid rate:	5
c. Equal to the Medicaid rate plus 1 to 5 percent:	113
d. Equal to the Medicaid rate plus 6 to 10 percent:	141
e. Equal to the Medicaid rate plus 11 to 15 percent:	247
f. Equal to the Medicaid rate plus more than 15 percent:	2,267
TOTAL:	2,924

Of the 3,893 contracts, 3,198 had contract rates for intermediate care. The benchmark levels for intermediate care are based on 90 percent of the skilled rates. Intermediate contract rates are not related to Medicaid rates.

5. **Question:** Is it realistic for medical centers to obtain care for veterans from community nursing homes at the established Medicaid rate? At 115 percent of the Medicaid rate? Please explain.

Response: We believe that it is reasonable for medical centers to use Medicaid rates plus 15 percent to negotiate contracts. However, our review disclosed that few medical centers negotiated contracts using that benchmark level. In most cases, Medicaid rates were good market value indicators of nursing home rates.

The majority of nursing home patients are Medicaid beneficiaries. While Medicaid rates for some homes we reviewed were slightly less than reported costs, we believe that the nursing homes would probably close if Medicaid rates truly caused revenue losses.

In States where Medicaid rates include ancillary services, those Medicaid rates would most likely cover costs of treating veterans. However, many Medicaid rates are for basic room and board, nursing care, and routine services. Those kinds of Medicaid rates do not include allowances for ancillary services, which are paid separately from nursing home Medicaid reimbursements. VA determined that up to 15 percent of Medicaid rates generally allowed a high enough contract price to cover, on an all-inclusive basis, veterans' costs.

While we found at most of the homes we reviewed that Medicaid plus 15 percent adequately covered, or exceeded, costs to treat veterans, instances occurred where this amount did not cover veterans' total costs of care. This was primarily due to the

ancillary care costs (particularly prescription drugs) that often could not be anticipated at the time contracts were negotiated.

Question: What other basis should be used for obtaining community nursing home care? Why?

Response: VA could award contracts for care based on audited nursing home cost reports. A basic daily cost could be determined from these reports. The daily cost figure could be used to negotiate VA contract rates.

As another alternative, VA could pay for veterans' care by applying the Medicaid reimbursement systems for Medicaid beneficiaries. The majority of nursing home patients are Medicaid beneficiaries. States reimburse nursing homes for Medicaid beneficiaries' room, board and nursing care on a per diem basis. States usually pay providers separately for ancillary costs. Since VA generally has not been successful in awarding contract rates close to Medicaid rates, VA could apply the Medicaid system to pay for veterans' care.

6. **Question:** How is the VA's maximum per diem rate for community nursing homes determined by the Department and what does this maximum rate represent? How is this rate related to Medicaid rates?

Response: We have been informed by VA Central Office Extended Care and Geriatrics Service officials that they initially determined the maximum per diem rate in the mid-1970's. VA records did not show the original ceiling. Program officials said that the ceiling was based on an upper percentile of prevailing contract rates. The purpose of the ceiling was to keep contract rates below the statutory limit of 45 percent of medical center per diem costs. The ceiling was unrelated to Medicaid rates.

According to Extended Care and Geriatrics Service officials, once they established a ceiling, it was evaluated each year and compared to increases in contract rates and market factors in general. They then determined the ceiling for the next year. For example, in 1988, the maximum was $87 a day; in 1989, $91 a day; and in 1990, the rate is $95 a day.

7. **Question:** Where are Medicaid rates not a reliable indicator of the current market value of nursing home care in the local community?

Response: We believe that, generally, Medicaid rates are reliable indicators of the current market value of nursing home care. We have indicators that Medicaid rates are not always as high as private-pay rates, unless States have an equalization law prohibiting rates higher than their Medicaid rates. In states with severe shortages of beds and high cost areas, such as New York, Medicaid rates were substantially less than private-pay and VA contract rates. In areas such as these, Medicaid rates may not be reliable indicators.

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